Washington State Department of Health Trauma Registry
Hospital Data Dictionary
Collector Version 3.37

General Definitions:

- Inappropriate (enter "I") means the information for a field does not apply to this patient (example: Pediatric trauma scores for adult patients). Also, see special instructions for use of Inappropriate in specific fields.
- Pediatric refers to patients 14 years old or younger.
- Unknown means the information is appropriate to this patient, but is not known or reasonably obtainable. Also, see special instructions for use of Unknown in specific fields.

Section	Screen	Data Element Description	Collector Data Name	Definition
Demographic	F1.1	Hospital Index	**HOSP_INDEX**	A unique number for each patient encounter. The DOH suggests that hospitals use their billing number. The hospital index, along with the hospital ID number (see INST_NUM), will uniquely identify this patient record.
Demographic	F1.1	Facility ID Number	**INST_NUM**	A number assigned by the state that is unique to this hospital. This, together with the hospital index (see HOSP_INDEX), will uniquely identify a patient record. ***Note: Unless you are using Central Site Collector, this number will be entered automatically. The list below shows designation levels current as of March 2005.*** **Central Region** 014 = Children's Hospital & Medical Center (Seattle), level I-Ped/Rehab 029 = Harborview Medical Center (HMC) (Seattle), level I/I-Ped/I-Rehab. 035 = Enumclaw Community Hospital (Enumclaw), level V 126 = Highline Community Hospital (Burien), level IV 130 = Northwest Hospital & Medical Center (Seattle), level IV/II-Rehab 131 = Overlake Hospital Medical Center (Bellevue), level III 155 = Valley Medical Center (Renton), level III/III-Rehab 164 = Evergreen Hospital Medical Center (Kirkland), level IV 183 = Auburn Regional Medical Center (Auburn), level III 201 = St. Francis Community Hospital (Federal Way), level IV **East Region** 021 = Newport Community Hospital (Newport), level IV 030 = Mount Carmel Hospital (Colville), level IV 037 = Deaconess Medical Center (Spokane), level II/II-Ped. 042 = Deer Park Hospital (Spokane), level IV 080 = Odessa Memorial Healthcare (Odessa), level V 082 = Garfield County Hospital District (Pomeroy), level V 108 = Tri-State Memorial Hospital (Clarkston), level IV 111 = East Adams Rural Hospital (Ritzville), level V 125 = Othello Community Hospital (Othello), level V 137 = Lincoln Hospital (Davenport), level IV 139 = Holy Family Hospital (Spokane), level III 153 = Whitman Hospital and Medical Center (Colfax), level V 157 = St Luke's Rehabilitation Institute (Spokane), level I-Rehab 162 = Sacred Heart Medical Center (Spokane), level II/II-Ped. 167 = Ferry County Memorial Hospital (Republic), level V 172 = Pullman Regional Hospital (Pullman), level III 180 = Valley Hospital & Medical Center (Spokane), level III 194 = St. Joseph Hospital (Chewelah), level IV 950 = St. Joseph Regional Medical Center (Lewiston, ID), level II/III-Ped. **North Region** 027 = Providence Everett Medical Center (Everett), level III/II-Rehab 073 = Skagit Valley Hospital (Mt. Vernon), level III 104 = Valley General Hospital (Monroe), level IV 106 = Cascade Valley Hospital (Arlington), level IV 138 = Stevens Hospital (Edmonds), level IV 145 = St. Joseph Hospital (Bellingham), level II/II-Rehab 156 = Whidbey General Hospital (Coupeville), level III

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				163 = Island Hospital (Anacortes), level III 964 = Inter-Island Medical Center (Friday Harbor), level V 965 = Darrington Clinic (Darrington), level V 967 = United General Hospital (Sedro-Woolley), level V **North Central Region** 023 = Okanogan-Douglas County Hospital (Brewster), level IV 045 = Columbia Basin Hospital (Ephrata), level V 078 = Samaritan Hospital (Moses Lake), level IV 107 = North Valley Hospital (Tonasket), level IV 129 = Quincy Valley Medical Center (Quincy), level V 147 = Mid-Valley Hospital (Omak), level IV 150 = Coulee Community Hospital (Grand Coulee), level IV 158 = Cascade Medical Center (Leavenworth), level V 165 = Lake Chelan Community Hospital (Chelan), level IV 168 = Central Washington Hospital (Wenatchee), level II/III-Ped. **Northwest Region** 038 = Olympic Medical Center (Port Angeles), level III 054 = Forks Community Hospital (Forks), level IV 085 = Jefferson General Hospital (Port Townsend), level IV 142 = Harrison Memorial Hospital (Bremerton), level III 152 = Mason General Hospital (Shelton), level IV **South Central Region** 022 = Lourdes Medical Center (Pasco), level III/II-Rehab 039 = Kennewick General Hospital (Kennewick), level III 044 = Walla Walla General Hospital (Walla Walla), level III 046 = Prosser Memorial Hospital (Prosser), level IV 050 = St. Mary Medical Center (Walla Walla), level III/III-Pediatric/II-Rehab 058 = Yakima Valley Memorial Hospital (Yakima), level III/III-Pediatric 102 = Yakima Regional Medical Center (Yakima), level III/III-Ped/II-Rehab 140 = Kittitas Valley Community Hospital (Ellensburg), level IV 141 = Dayton General Hospital (Dayton), level V 161 = Kadlec Medical Center (Richland), level III/II-Rehab 198 = Sunnyside Community Hospital (Sunnyside), level III 199 = Toppenish Community Hospital (Toppenish), level IV **Southwest Region** 08 = Klickitat Valley Hospital (Goldendale), level IV 026 = St. John Medical Center (Longview), level III 079 = Ocean Beach Hospital (Ilwaco), level IV 096 = Skyline Hospital (White Salmon), level IV 170 = Southwest Washington Medical Center (Vancouver), level II/II-Rehab **West Region** 032 = St. Joseph Medical Center (Tacoma), level II/II-Rehab 056 = Willapa Harbor Hospital (South Bend), level IV 063 = Grays Harbor Community Hospital (Aberdeen), level III 081 = Good Samaritan Community Healthcare (Puyallup), level III/I-Rehab (Heath Rehab Center) 132 = St. Clare Hospital (Lakewood), level IV 159 = Providence St. Peter Hospital (Olympia), level III/II-Rehab 173 = Morton General Hospital (Morton), level IV 175 = Mary Bridge Children's Hospital (Tacoma), level II-Ped. 176 = Tacoma General Hospital (Tacoma), level II 186 = Mark Reed Hospital (McCleary), level V 191 = Providence Centralia Hospital (Centralia), level III 197 = Capital Medical Center (Olympia), level IV 720 = Madigan Army Medical Center (Fort Lewis), level II

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Demographic	F1.1	Trauma ID Number	**TRAUMA_NUM**	Normally this will be the number on a Trauma Wrist Band applied to the patient by the pre-hospital personnel. If the wristband was not applied, this number is assigned by the hospital using a unique trauma wristband number provided by DOH. If the hospital assigns the Trauma Number, it is recommended that the pre-hospital agencies involved with that patient be informed of the number.
Demographic	F1.1	Abstractor	ABSTRACTOR	Indicates the ID number (if your facility has assigned one) or initials of the person abstracting the data for Collector.
Demographic	F1.1	Accession Number	ACC_NUM	Reserved for DOH linking purposes.
Demographic	F1.1	Abstraction Date	ABS_DATE	The latest date that information was entered or modified for this patient record. If adding a record, today's date is automatically filled in. If modifying a previously closed record, you must override the field with today's date.
Demographic	F1.1	Abstraction Month	ABS_DATE_M	Month portion of the Abstraction Date. Valid values range from 1 to 12.
Demographic	F1.1	Abstraction Day	ABS_DATE_D	Day portion of the Abstraction Date. Valid values range from 1 to 31.
Demographic	F1.1	Abstraction Year	ABS_DATE_Y	Year portion of the Abstraction Date. Valid values are from 1980 to 2099.
Demographic	F1.1	Patient ID Number	**PAT_ID_NUM**	The unique number assigned by your facility to this patient within your hospital (but not necessarily unique to this patient encounter). This is the patient's medical record number. DO NOT USE THE TRAUMA BAND NUMBER HERE. **Note: Do not use (U)nknown or (I)nappropriate in this field.**
Demographic	F1.1	Readmission	**READMIT**	Indicates whether this patient is in your facility for follow-up care from a trauma. A "YES" will not be counted as emergent care. Readmissions are only included in the registry if there was a missed diagnosis at the time of the original admission to your hospital. If yes is entered, please indicate the date of the original admission and the injury memo on screen F2.3. Also enter #25=missed injury in one of the 3 ED Care Issues on Screen F4.3. 1 = Yes 2 = No Note: (I)nappropriate or (U)nknown are not valid values for this data element.
Demographic	F1.1	Patient Name	**PAT_NAME**	Indicates the patient's full name, including the last, first, and middle initial.
Demographic	F1.1	Patient Last Name	**PAT_NAM_LH**	Enter the ***full*** last name. **Note: *Do not* enter the letters "U" or "I". If unknown, enter an asterisk (*).**
Demographic	F1.1	Patient First Name	**PAT_NAM_FH**	Enter the ***full*** first name -- do not use initial(s) unless the patient's first name consists of initial(s). **Note: *Do not* enter "U" or "I". If unknown, enter an asterisk (*).**
Demographic	F1.1	Patient Middle Initial	**PAT_NAM_MH**	The patient's middle name ***Note: Do not* enter "U" or "I". If unknown, enter an asterisk (*).**
Demographic	F1.1	Date of Birth	**DOB_TEXT**	The patient's date of birth.
Demographic	F1.1	DOB Month	**DOB_MH**	Month portion of the patient's date of birth. Valid values range from 1 to 12.
Demographic	F1.1	DOB Day	**DOB_DH**	Day portion of the patient's date of birth. Valid values range from 1 to 31.

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Demographic	F1.1	DOB Year	**DOB_YH**	Year portion of the patient's date of birth. ***Enter all 4 digits.*** Valid values are from *1850 - 2098*.
Demographic	F1.1	Patient Age Entered by Abstractor	RAW_AGEH	Enter the Patient age if DOB is unknown. It is based on information received from the patient's family or other reliable source. If the patient is under 1 year, enter number of *months*; if under one month, enter number of *days*. If the patient is 1 year or older, enter number of *years*. Always attempt to estimate the age. If medical personnel estimate the age, enter the number of estimated years. Allowed values range from 1 to 120. See also AGE_TYPE, AGE. Note: There is only a single AGE field on the Collector screen.
Demographic	F1.1	Age	**AGE**	Indicates the patient's age at ED arrival date. It is automatically calculated by Collector if date of birth (DOB) is entered, using DOB and the ED arrival date. The patient age will initially be computed as the age at date of abstraction. However, once the ED arrival date is entered, the age field will automatically be refreshed with the correct patient age. If the DOB is unknown, Collector will take the value of the raw age entered by the user (see RAW_AGE, AGE_TYPE) and round to the nearest *year.* *Example 1: On abstraction date 1/1/1998, the patient's DOB is entered as 1/1/1991. The patient AGE is automatically displayed on the Collector screen as 7. When the abstractor later enters the ED arrival date of 3/3/1996, the age is automatically modified to 5.* *Example 2: The age is manually entered because DOB is unknown. The patient age is 5 months (family verified), so 5 is entered for the age, and 2 (=months) is entered for age units. The value of AGE in this case is zero, and the value of RAW_AGE is 5. If the entered age is 6 months, the value of AGE is 1, and the value of RAW_AGE is 6. This distinction is important when writing reports.* See also RAW_AGE.
Demographic	F1.1	In (Age Units)	**AGE_TYPE**	The age units corresponding to the patient's age. If Collector automatically calculated patient age (see AGE), the age units field is automatically set by Collector as option 4 - "Estimated, in Years"; then, when the EDA is entered, the units field is updated to 1-"Years". If, however, the abstractor manually entered the patient's age (see RAW_AGE), then the age units are manually entered by the abstractor as shown below. 1 = Years 2 = Months 3 = Days 4 = Estimated, in Years
Demographic	F1.1	Sex	**SEXH**	1 = Male 2 = Female
Demographic ***NEW ELEMENT***	F1.1	Pregnant	PREGNANCY	Indicates whether the patient was pregnant at the time. 1 = Yes 2 = No
Demographic	F1.1	Race	**RACEH**	The race of the patient as stated by the patient or next of kin. Note: Hispanic is considered a national origin, not a race. If Hispanic is given as a response with no additional information, enter U or * for unknown in this field, *and enter a 1 for the ethnicity field* (see ETHNICITYH). 1 = White 2 = Black 3 = Native American (American Indian, Eskimo, Aleut) 4 = Asian or Pacific Islanders (Asian includes Chinese, Filipino, Japanese,

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				Asian Indian, Korean, Vietnamese, Cambodian, Hmong, Laotian, Thai, and other Asian. Pacific Islander includes Hawaiian, Samoan, Guam, Tongan, Other Polynesian, Other Micronesian, Melanesian, and other Pacific Islander.) 5 = Other
Demographic	F1.1	Ethnicity	**ETHNICITYH**	Note: Persons of Hispanic origin may be of any race. See also RACEH. 1 = Hispanic Origin 2 = Non-Hispanic Origin
Demographic	F1.1	Social Security Number	**SSN**	The patient's social security number. If patient does not have a social security number (e.g. is not a US citizen), or the SSN is unknown, enter * or U in all three social security fields. See SOC_SEC_1H, SOC_SEC_2H, and SOC_SEC_3H.
Demographic	F1.1	SSN Part 1	**SOC_SEC_1H**	The first part (3 digits) of the patient's social security number. If unknown, enter *.
Demographic	F1.1	SSN Part 2	**SOC_SEC_2H**	The second part (2 digits) of the patient's social security number. If unknown, enter *.
Demographic	F1.1	SSN Part 3	**SOC_SEC_3H**	The third part (4 digits) of the patient's social security number. In unknown, enter *.
Demographic	F1.1	Home Zip Code	**PAT_ADR_Z**	Zip code of the patient's residence.
Demographic	F1.2	Demographics Memo	NOTES_DEMO	Ten lines designated for a description of patient's demographic information.
Injury Data	F2.1	Injury Date	**INJ_DATE**	Date that the patient was injured. *(Note: Order of preference for source is pre-hospital 'run sheet', referring hospital records, your hospital's ED records, police report, other.)*
Injury Data	F2.1	Injury Month	**INJ_DATE_M**	Month that the patient was injured. Valid values are from 1 to 12. See INJ_DATE for a complete definition.
Injury Data	F2.1	Injury Day	**INJ_DATE_D**	Day that the patient was injured. Valid values are from 1 to 31. See INJ_DATE for a complete definition.
Injury Data	F2.1	Injury Year	**INJ_DATE_Y**	Year that the patient was injured. Valid values are from 1980 to 2099. See INJ_DATE for a complete definition.
Injury Data	F2.1	Injury Time	**INJ_TIME**	Time that the patient was injured. (Note: Order of preference for source is pre-hospital 'run sheet', referring hospital records, your hospital's ED records, police report, other.)
Injury Data	F2.1	Injury Hour	**INJ_TIME_H**	Hour that the patient was injured. Valid values are from 0 to 23. See INJ_TIME for a complete definition.
Injury Data	F2.1	Injury Minutes	**INJ_TIME_M**	'Minutes' portion of time that the patient was injured. Valid values are from 0 to 59. See INJ_TIME for a complete definition.
Injury Data	F2.1	Zip Code of Place of Injury	ZIP_INJ	Zip Code of Place of Injury.
Injury Data	F2.1	Place of Injury Occurrence	**E849_X**	The option entered best describes the place where the injury occurred. These options are taken in part from the E849 category for injury location using the ICD-9-CM coding manual for reference. Refer to ICD-9-CM coding manual for a complete description of these codes. 0 = Home

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				1 = Farm (exclude farmhouse) 2 = Mine/Quarry 3 = Industrial Place 4 = Place for Sports or Recreation 5 = Street or Highway 6 = Public Building 7 = Residential Institution 8 = Other Specified Place 9 = Unspecified Place NOTE: See Appendix for a more complete description of these codes.
Injury Data	F2.1	Injury Description Details	NOTES_INJD	Ten lines designated for a description of patient's injury.
Injury Data	F2.2	Primary E-Code	**E_CODE**	Primary E-Code using standard ICD-9-CM E-Codes. For further information about use of these codes, refer to ICDM-9-CM coding manual **CODE DESCRIPTION** **Railway Accidents** 800.0 = Railway Collision w/ Rolling Stock - Railway Employee 800.1 = Railway Collision w/ Rolling Stock - Railway Passenger 800.2 = Railway Collision w/ Rolling Stock – Pedestrian 800.3 = Railway Collision w/ Rolling Stock - Pedal Cyclist 800.8 = Railway Collision w/ Rolling Stock - Oth Person 800.9 = Railway Collision w/ Rolling Stock - Unspec Person 801.0 = Railway Collision w/ Oth Object - Railway Employee 801.1 = Railway Collision w/ Oth Object - Railway Passenger 801.2 = Railway Collision w/ Oth Object – Pedestrian 801.3 = Railway Collision w/ Oth Object - Pedal Cyclist 801.8 = Railway Collision w/ Oth Object - Oth Person 801.9 = Railway Collision w/ Oth Object - Unspec Person 802.0 = Railway Derailment w/o Prior Collision - Railway Employee 802.1 = Railway Derailment w/o Prior Collision - Railway Passenger 802.2 = Railway Derailment w/o Prior Collision – Pedestrian 802.3 = Railway Derailment w/o Prior Collision - Pedal Cyclist 802.8 = Railway Derailment w/o Prior Collision - Oth Person 802.9 = Railway Derailment w/o Prior Collision - Unspec Person 803.0 = Railway Explosion, Fire, or Burning - Railway Employee 803.1 = Railway Explosion, Fire, or Burning - Railway Passenger 803.2 = Railway Explosion, Fire, or Burning – Pedestrian 803.3 = Railway Explosion, Fire, or Burning - Pedal Cyclist 803.8 = Railway Explosion, Fire, or Burning - Oth Person 803.9 = Railway Explosion, Fire, or Burning - Unspec Person 804.0 = Fall In, On, or From Railway Train - Railway Employee 804.1 = Fall In, On, or From Railway Train - Railway Passenger 804.2 = Fall In, On, or From Railway Train – Pedestrian 804.3 = Fall In, On, or From Railway Train - Pedal Cyclist 804.8 = Fall In, On, or From Railway Train - Oth Person 804.9 = Fall In, On, or From Railway Train - Unspec Person 805.0 = Railway, Hit by Rolling Stock - Railway Employee 805.1 = Railway, Hit by Rolling Stock - Railway Passenger 805.2 = Railway, Hit by Rolling Stock – Pedestrian 805.3 = Railway, Hit by Rolling Stock - Pedal Cyclist 805.8 = Railway, Hit by Rolling Stock - Oth Person 805.9 = Railway, Hit by Rolling Stock - Unspec Person 806.0 = Oth Spec Railway Accident - Railway Employee 806.1 = Oth Spec Railway Accident - Railway Passenger 806.2 = Oth Spec Railway Accident – Pedestrian 806.3 = Oth Spec Railway Accident - Pedal Cyclist

Section	Screen	Data Element Description	Collector Data Name	Definition
				806.8 = Oth Spec Railway Accident - Oth Person 806.9 = Oth Spec Railway Accident - Unspec Person 807.0 = Railway, Unspec Nature - Railway Employee 807.1 = Railway, Unspec Nature - Railway Passenger 807.2 = Railway, Unspec Nature - Pedestrian 807.3 = Railway, Unspec Nature - Pedal Cyclist 807.8 = Railway, Unspec Nature - Oth Person 807.9 = Railway, Unspec Nature - Unspec Person **Motor Vehicle Traffic Accidents** 810.0 = MVA Traffic, Collision w/ Train - Driver of MV, Non MC 810.1 = MVA Traffic, Collision w/ Train - Passenger in MV, Non MC 810.2 = MVA Traffic, Collision w/ Train - Motorcyclist 810.3 = MVA Traffic, Collision w/ Train - Passenger on Motorcycle 810.4 = MVA Traffic, Collision w/ Train - Occupant of Streetcar 810.5 = MVA Traffic, Collision w/ Train - Occupant of Animal Veh 810.6 = MVA Traffic, Collision w/ Train - Pedal Cyclist 810.7 = MVA Traffic, Collision w/ Train - Pedestrian 810.8 = MVA Traffic, Collision w/ Train - Oth Person 810.9 = MVA Traffic, Collision w/ Train - Unspec Person 811.0 = MVA Traffic, Re-entr Collision w/ MV - Driver of MV, Non MC 811.1 = MVA Traffic, Re-entr Collision w/ MV - Passenger in MV, Non MC 811.2 = MVA Traffic, Re-entr Collision w/ MV - Motorcyclist 811.3 = MVA Traffic, Re-entr Collision w/ MV - Passenger on Motorcycle 811.4 = MVA Traffic, Re-entr Collision w/ MV - Occupant of Streetcar 811.5 = MVA Traffic, Re-entr Collision w/ MV - Occupant of Animal Veh 811.6 = MVA Traffic, Re-entr Collision w/ MV - Pedal Cyclist 811.7 = MVA Traffic, Re-entr Collision w/ MV - Pedestrian 811.8 = MVA Traffic, Re-entr Collision w/ MV - Oth Person 811.9 = MVA Traffic, Re-entr Collision w/ MV - Unspec Person 812.0 = Oth MVA Traffic, Collision w/ MV - Driver of MV, Non MC 812.1 = Oth MVA Traffic, Collision w/ MV - Passenger in MV, Non MC 812.2 = Oth MVA Traffic, Collision w/ MV - Motorcyclist 812.3 = Oth MVA Traffic, Collision w/ MV - Passenger on Motorcycle 812.4 = Oth MVA Traffic, Collision w/ MV - Occupant of Streetcar 812.5 = Oth MVA Traffic, Collision w/ MV - Occupant of Animal Veh 812.6 = Oth MVA Traffic, Collision w/ MV - Pedal Cyclist 812.7 = Oth MVA Traffic, Collision w/ MV - Pedestrian 812.8 = Oth MVA Traffic, Collision w/ MV - Oth Person 812.9 = Oth MVA Traffic, Collision w/ MV - Unspec Person 813.0 = MVA Traffic, Collision w/ Oth Veh - Driver of MV, Non MC 813.1 = MVA Traffic, Collision w/ Oth Veh - Passenger in MV, Non MC 813.2 = MVA Traffic, Collision w/ Oth Veh - Motorcyclist 813.3 = MVA Traffic, Collision w/ Oth Veh - Passenger on Motorcycle 813.4 = MVA Traffic, Collision w/ Oth Veh - Occupant of Streetcar 813.5 = MVA Traffic, Collision w/ Oth Veh - Occupant of Animal Veh 813.6 = MVA Traffic, Collision w/ Oth Veh - Pedal Cyclist 813.7 = MVA Traffic, Collision w/ Oth Veh - Pedestrian 813.8 = MVA Traffic, Collision w/ Oth Veh - Oth Person 813.9 = MVA Traffic, Collision w/ Oth Veh - Unspec Person 814.0 = MVA Traffic, Collision w/ Pedestrian - Driver of MV, Non MC 814.1 = MVA Traffic, Collision w/ Pedestrian - Passenger in MV, Non MC 814.2 = MVA Traffic, Collision w/ Pedestrian - Motorcyclist 814.3 = MVA Traffic, Collision w/ Pedestrian - Passenger on Motorcycle 814.4 = MVA Traffic, Collision w/ Pedestrian - Occupant of Streetcar 814.5 = MVA Traffic, Collision w/ Pedestrian - Occupant of Animal Veh 814.6 = MVA Traffic, Collision w/ Pedestrian - Pedal Cyclist 814.7 = MVA Traffic, Collision w/ Pedestrian - Pedestrian 814.8 = MVA Traffic, Collision w/ Pedestrian - Oth Person 814.9 = MVA Traffic, Collision w/ Pedestrian - Unspec Person 815.0 = Oth MVA Traffic, Highway Collision - Driver of MV, Non MC

Section	Screen	Data Element Description	Collector Data Name	Definition
				815.1 = Oth MVA Traffic, Highway Collision - Passenger in MV, Non MC 815.2 = Oth MVA Traffic, Highway Collision - Motorcyclist 815.3 = Oth MVA Traffic, Highway Collision - Passenger on Motorcycle 815.4 = Oth MVA Traffic, Highway Collision - Occupant of Streetcar 815.5 = Oth MVA Traffic, Highway Collision - Occupant of Animal Veh 815.6 = Oth MVA Traffic, Highway Collision - Pedal Cyclist 815.7 = Oth MVA Traffic, Highway Collision - Pedestrian 815.8 = Oth MVA Traffic, Highway Collision - Oth Person 815.9 = Oth MVA Traffic, Highway Collision - Unspec Person 816.0 = MVA Traffic, Loss Control-No Collision - Driver of MV, Non MC 816.1 = MVA Traffic, Loss Control-No Collision - Passenger in MV, Non MC 816.2 = MVA Traffic, Loss Control-No Collision - Motorcyclist 816.3 = MVA Traffic, Loss Control-No Collision - Passenger on Motorcycle 816.4 = MVA Traffic, Loss Control-No Collision - Occupant of Streetcar 816.5 = MVA Traffic, Loss Control-No Collision - Occupant of Animal Veh 816.6 = MVA Traffic, Loss Control-No Collision - Pedal Cyclist 816.7 = MVA Traffic, Loss Control-No Collision - Pedestrian 816.8 = MVA Traffic, Loss Control-No Collision - Oth Person 816.9 = MVA Traffic, Loss Control-No Collision - Unspec Person 817.0 = Noncollision MVA Traffic, Board/Alight - Driver of MV, Non MC 817.1 = Noncollision MVA Traffic, Board/Alight - Passenger in MV, Non MC 817.2 = Noncollision MVA Traffic, Board/Alight - Motorcyclist 817.3 = Noncollision MVA Traffic, Board/Alight - Passenger on Motorcycle 817.4 = Noncollision MVA Traffic, Board/Alight - Occupant of Streetcar 817.5 = Noncollision MVA Traffic, Board/Alight - Occupant of Animal Veh 817.6 = Noncollision MVA Traffic, Board/Alight - Pedal Cyclist 817.7 = Noncollision MVA Traffic, Board/Alight - Pedestrian 817.8 = Noncollision MVA Traffic, Board/Alight - Oth Person 817.9 = Noncollision MVA Traffic, Board/Alight - Unspec Person 818.0 = Oth Noncollision MVA Traffic - Driver of MV, Non MC 818.1 = Oth Noncollision MVA Traffic - Passenger in MV, Non MC 818.2 = Oth Noncollision MVA Traffic - Motorcyclist 818.3 = Oth Noncollision MVA Traffic - Passenger on Motorcycle 818.4 = Oth Noncollision MVA Traffic - Occupant of Streetcar 818.5 = Oth Noncollision MVA Traffic - Occupant of Animal Veh 818.6 = Oth Noncollision MVA Traffic - Pedal Cyclist 818.7 = Oth Noncollision MVA Traffic - Pedestrian 818.8 = Oth Noncollision MVA Traffic - Oth Person 818.9 = Oth Noncollision MVA Traffic - Unspec Person 819.0 = MVA Traffic, Unspec Nature - Driver of MV, Non MC 819.1 = MVA Traffic, Unspec Nature - Passenger in MV, Non MC 819.2 = MVA Traffic, Unspec Nature - Motorcyclist 819.3 = MVA Traffic, Unspec Nature - Passenger on Motorcycle 819.4 = MVA Traffic, Unspec Nature - Occupant of Streetcar 819.5 = MVA Traffic, Unspec Nature - Occupant of Animal Veh 819.6 = MVA Traffic, Unspec Nature - Pedal Cyclist 819.7 = MVA Traffic, Unspec Nature - Pedestrian 819.8 = MVA Traffic, Unspec Nature - Oth Person 819.9 = MVA Traffic, Unspec Nature - Unspec Person **Motor Vehicle Nontraffic Accidents** 820.0 = N-traffic Accident, Snow MV - Driver of MV, Non MC 820.1 = N-traffic Accident, Snow MV - Passenger in MV, Non MC 820.2 = N-traffic Accident, Snow MV - Motorcyclist 820.3 = N-traffic Accident, Snow MV - Passenger on Motorcycle 820.4 = N-traffic Accident, Snow MV - Occupant of Streetcar 820.5 = N-traffic Accident, Snow MV - Occupant of Animal Veh 820.6 = N-traffic Accident, Snow MV - Pedal Cyclist 820.7 = N-traffic Accident, Snow MV - Pedestrian 820.8 = N-traffic Accident, Snow MV - Oth Person 820.9 = N-traffic Accident, Snow MV - Unspec Person

Section	Screen	Data Element Description	Collector Data Name	Definition
				821.0 = N-traffic Accident, Oth Off-Road MV - Driver of MV, Non MC 821.1 = N-traffic Accident, Oth Off-Road MV - Passenger in MV, Non MC 821.2 = N-traffic Accident, Oth Off-Road MV - Motorcyclist 821.3 = N-traffic Accident, Oth Off-Road MV - Passenger on Motorcycle 821.4 = N-traffic Accident, Oth Off-Road MV - Occupant of Streetcar 821.5 = N-traffic Accident, Oth Off-Road MV - Occupant of Animal Veh 821.6 = N-traffic Accident, Oth Off-Road MV - Pedal Cyclist 821.7 = N-traffic Accident, Oth Off-Road MV - Pedestrian 821.8 = N-traffic Accident, Oth Off-Road MV - Oth Person 821.9 = N-traffic Accident, Oth Off-Road MV - Unspec Person 822.0 = Oth MVA N-traffic Collision,Move Object - Driver of MV, Non MC 822.1 = Oth MVA N-traffic Collision,Move Object - Passenger in MV, Non MC 822.2 = Oth MVA N-traffic Collision,Move Object - Motorcyclist 822.3 = Oth MVA N-traffic Collision,Move Object - Passenger on Motorcycle 822.4 = Oth MVA N-traffic Collision,Move Object - Occupant of Streetcar 822.5 = Oth MVA N-traffic Collision,Move Object - Occupant of Animal Veh 822.6 = Oth MVA N-traffic Collision,Move Object - Pedal Cyclist 822.7 = Oth MVA N-traffic Collision,Move Object - Pedestrian 822.8 = Oth MVA N-traffic Collision,Move Object - Oth Person 822.9 = Oth MVA N-traffic Collision,Move Object - Unspec Person 823.0 = Oth MVA N-Traffic Collision,Stat Object - Driver of MV, Non MC 823.1 = Oth MVA N-Traffic Collision,Stat Object - Passenger in MV, Non MC 823.2 = Oth MVA N-Traffic Collision,Stat Object - Motorcyclist 823.3 = Oth MVA N-Traffic Collision,Stat Object - Passenger on Motorcycle 823.4 = Oth MVA N-Traffic Collision,Stat Object - Occupant of Streetcar 823.5 = Oth MVA N-Traffic Collision,Stat Object - Occupant of Animal Veh 823.6 = Oth MVA N-Traffic Collision,Stat Object - Pedal Cyclist 823.7 = Oth MVA N-Traffic Collision,Stat Object - Pedestrian 823.8 = Oth MVA N-Traffic Collision,Stat Object - Oth Person 823.9 = Oth MVA N-Traffic Collision,Stat Object - Unspec Person 824.0 = Oth MVA N-Traffic, Board/Alight - Driver of MV, Non MC 824.1 = Oth MVA N-Traffic, Board/Alight - Passenger in MV, Non MC 824.2 = Oth MVA N-Traffic, Board/Alight - Motorcyclist 824.3 = Oth MVA N-Traffic, Board/Alight - Passenger on Motorcycle 824.4 = Oth MVA N-Traffic, Board/Alight - Occupant of Streetcar 824.5 = Oth MVA N-Traffic, Board/Alight - Occupant of Animal Veh 824.6 = Oth MVA N-Traffic, Board/Alight - Pedal Cyclist 824.7 = Oth MVA N-Traffic, Board/Alight - Pedestrian 824.8 = Oth MVA N-Traffic, Board/Alight - Oth Person 824.9 = Oth MVA N-Traffic, Board/Alight - Unspec Person 825.0 = Oth MVA N-Traffic, Oth & Unspec Nature - Driver of MV, Non MC 825.1 = Oth MVA N-Traffic, Oth & Unspec Nature - Passenger in MV, Non MC 825.2 = Oth MVA N-Traffic, Oth & Unspec Nature - Motorcyclist 825.3 = Oth MVA N-Traffic, Oth & Unspec Nature - Passenger on Motorcycle 825.4 = Oth MVA N-Traffic, Oth & Unspec Nature - Occupant of Streetcar 825.5 = Oth MVA N-Traffic, Oth & Unspec Nature - Occupant of Animal Veh 825.6 = Oth MVA N-Traffic, Oth & Unspec Nature - Pedal Cyclist 825.7 = Oth MVA N-Traffic, Oth & Unspec Nature - Pedestrian 825.8 = Oth MVA N-Traffic, Oth & Unspec Nature - Oth Person 825.9 = Oth MVA N-Traffic, Oth & Unspec Nature - Unspec Person **Other Road Vehicle Accidents** 826.0 = Pedal Cycle Accident - Pedestrian 826.1 = Pedal Cycle Accident - Pedal Cyclist 826.2 = Pedal Cycle Accident - Rider of Animal 826.3 = Pedal Cycle Accident - Occupant of Animal-Drawn Veh 826.4 = Pedal Cycle Accident - Occupant of Streetcar 826.8 = Pedal Cycle Accident - Oth Person 826.9 = Pedal Cycle Accident - Unspec Person 827.0 = Animal-Drawn Veh Accident - Pedestrian 827.2 = Animal-Drawn Veh Accident - Rider of Animal

Section	Screen	Data Element Description	Collector Data Name	Definition
				827.3 = Animal-Drawn Veh Accident - Occupant of Animal-Drawn Veh 827.4 = Animal-Drawn Veh Accident - Occupant of Streetcar 827.8 = Animal-Drawn Veh Accident - Oth Person 827.9 = Animal-Drawn Veh Accident - Unspec Person 828.0 = Accident, Ridden Animal - Pedestrian 828.2 = Accident, Ridden Animal - Rider of Animal 828.3 = Accident, Ridden Animal - Occupant of Animal-Drawn Veh 828.4 = Accident, Ridden Animal - Occupant of Streetcar 828.8 = Accident, Ridden Animal - Oth Person 828.9 = Accident, Ridden Animal - Unspec Person 829.0 = Oth Road Veh Accidents - Pedestrian 829.4 = Oth Road Veh Accidents - Occupant of Streetcar 829.8 = Oth Road Veh Accidents - Oth Person 829.9 = Oth Road Veh Accidents - Unspec Person **Water Transport Accidents** 830.0 = H2OCraft Accident, Submersion - Small Boater (Unpowered) 830.1 = H2OCraft Accident, Submersion - Small Boater (Powered) 830.2 = H2OCraft Accident, Submersion - Crew of Oth H2OCraft 830.3 = H2OCraft Accident, Submersion - Pass of Oth H2OCraft 830.4 = H2OCraft Accident, Submersion - H2O Skier 830.5 = H2OCraft Accident, Submersion - Swimmer 830.6 = H2OCraft Accident, Submersion - Dockers/Stevedores 830.8 = H2OCraft Accident, Submersion - Oth Person 830.9 = H2OCraft Accident, Submersion - Unspec Person 831.0 = H2OCraft Accident, Oth Injury - Small Boater (Unpowered) 831.1 = H2OCraft Accident, Oth Injury - Small Boater (Powered) 831.2 = H2OCraft Accident, Oth Injury - Crew of Oth H2OCraft 831.3 = H2OCraft Accident, Oth Injury - Pass of Oth H2OCraft 831.4 = H2OCraft Accident, Oth Injury - H2O Skier 831.5 = H2OCraft Accident, Oth Injury - Swimmer 831.6 = H2OCraft Accident, Oth Injury - Dockers/Stevedores 831.8 = H2OCraft Accident, Oth Injury - Oth Person 831.9 = H2OCraft Accident, Oth Injury - Unspec Person 832.0 = H2O Transport, Oth Submersion/Drown - Small Boater (Unpowered) 832.1 = H2O Transport, Oth Submersion/Drown - Small Boater (Powered) 832.2 = H2O Transport, Oth Submersion/Drown - Crew of Oth H2OCraft 832.3 = H2O Transport, Oth Submersion/Drown - Pass of Oth H2OCraft 832.4 = H2O Transport, Oth Submersion/Drown - H2O Skier 832.5 = H2O Transport, Oth Submersion/Drown - Swimmer 832.6 = H2O Transport, Oth Submersion/Drown - Dockers/Stevedores 832.8 = H2O Transport, Oth Submersion/Drown - Oth Person 832.9 = H2O Transport, Oth Submersion/Drown - Unspec Person 833.0 = H2O Transport, Stairs/Ladders Fall - Small Boater (Unpowered) 833.1 = H2O Transport, Stairs/Ladders Fall - Small Boater (Powered) 833.2 = H2O Transport, Stairs/Ladders Fall - Crew of Oth H2OCraft 833.3 = H2O Transport, Stairs/Ladders Fall - Pass of Oth H2OCraft 833.4 = H2O Transport, Stairs/Ladders Fall - H2O Skier 833.5 = H2O Transport, Stairs/Ladders Fall - Swimmer 833.6 = H2O Transport, Stairs/Ladders Fall - Dockers/Stevedores 833.8 = H2O Transport, Stairs/Ladders Fall - Oth Person 833.9 = H2O Transport, Stairs/Ladders Fall - Unspec Person 834.0 = H2O Transport, Oth Multi-level Fall - Small Boater (Unpowered) 834.1 = H2O Transport, Oth Multi-level Fall - Small Boater (Powered) 834.2 = H2O Transport, Oth Multi-level Fall - Crew of Oth H2OCraft 834.3 = H2O Transport, Oth Multi-level Fall - Pass of Oth H2OCraft 834.4 = H2O Transport, Oth Multi-level Fall - H2O Skier 834.5 = H2O Transport, Oth Multi-level Fall - Swimmer 834.6 = H2O Transport, Oth Multi-level Fall - Dockers/Stevedores 834.8 = H2O Transport, Oth Multi-level Fall - Oth Person 834.9 = H2O Transport, Oth Multi-level Fall - Unspec Person

Section	Screen	Data Element Description	Collector Data Name	Definition
				835.0 = H2O Transport, Oth & Unspec Fall - Small Boater (Unpowered) 835.1 = H2O Transport, Oth & Unspec Fall - Small Boater (Powered) 835.2 = H2O Transport, Oth & Unspec Fall - Crew of Oth H2OCraft 835.3 = H2O Transport, Oth & Unspec Fall - Pass of Oth H2OCraft 835.4 = H2O Transport, Oth & Unspec Fall - H2O Skier 835.5 = H2O Transport, Oth & Unspec Fall - Swimmer 835.6 = H2O Transport, Oth & Unspec Fall - Dockers/Stevedores 835.8 = H2O Transport, Oth & Unspec Fall - Oth Person 835.9 = H2O Transport, Oth & Unspec Fall - Unspec Person 836.0 = H2O Transport, Machinery Accident - Small Boater (Unpowered) 836.1 = H2O Transport, Machinery Accident - Small Boater (Powered) 836.2 = H2O Transport, Machinery Accident - Crew of Oth H2OCraft 836.3 = H2O Transport, Machinery Accident - Pass of Oth H2OCraft 836.4 = H2O Transport, Machinery Accident - H2O Skier 836.5 = H2O Transport, Machinery Accident - Swimmer 836.6 = H2O Transport, Machinery Accident - Dockers/Stevedores 836.8 = H2O Transport, Machinery Accident - Oth Person 836.9 = H2O Transport, Machinery Accident - Unspec Person 837.0 = H2OCraft Explosion, Fire, or Burning - Small Boater (Unpowered) 837.1 = H2OCraft Explosion, Fire, or Burning - Small Boater (Powered) 837.2 = H2OCraft Explosion, Fire, or Burning - Crew of Oth H2OCraft 837.3 = H2OCraft Explosion, Fire, or Burning - Pass of Oth H2OCraft 837.4 = H2OCraft Explosion, Fire, or Burning - H2O Skier 837.5 = H2OCraft Explosion, Fire, or Burning - Swimmer 837.6 = H2OCraft Explosion, Fire, or Burning - Dockers/Stevedores 837.8 = H2OCraft Explosion, Fire, or Burning - Oth Person 837.9 = H2OCraft Explosion, Fire, or Burning - Unspec Person 838.0 = Oth & Unspec H2O Transport Accident - Small Boater (Unpowered) 838.1 = Oth & Unspec H2O Transport Accident - Small Boater (Powered) 838.2 = Oth & Unspec H2O Transport Accident - Crew of Oth H2OCraft 838.3 = Oth & Unspec H2O Transport Accident - Pass of Oth H2OCraft 838.4 = Oth & Unspec H2O Transport Accident - H2O Skier 838.5 = Oth & Unspec H2O Transport Accident - Swimmer 838.6 = Oth & Unspec H2O Transport Accident - Dockers/Stevedores 838.8 = Oth & Unspec H2O Transport Accident - Oth Person 838.9 = Oth & Unspec H2O Transport Accident - Unspec Person **Air and Space Transport Accidents** 840.0 = Powered Aircraft, Tkoff/Land - Spacecraft Occupant 840.1 = Powered Aircraft, Tkoff/Land - Military Aircraft Occupant 840.2 = Powered Aircraft, Tkoff/Land - Ground-Ground Commercial Crew 840.3 = Powered Aircraft, Tkoff/Land - Ground-Ground Commercial Occupant 840.4 = Powered Aircraft, Tkoff/Land - Ground-Air Commercial Occupant 840.5 = Powered Aircraft, Tkoff/Land - Oth Powered Aircraft Occupant 840.6 = Powered Aircraft, Tkoff/Land - Unpowered Aircraft Occupant 840.7 = Powered Aircraft, Tkoff/Land - Parachutist 840.8 = Powered Aircraft, Tkoff/Land - Ground Crew/Airline Employee 840.9 = Powered Aircraft, Tkoff/Land - Oth Person 841.0 = Oth & Unspec Powered Aircraft - Spacecraft Occupant 841.1 = Oth & Unspec Powered Aircraft - Military Aircraft Occupant 841.2 = Oth & Unspec Powered Aircraft - Ground-Ground Commercial Crew 841.3 = Oth & Unspec Powered Aircraft - Ground-Ground Commercial Occupant 841.4 = Oth & Unspec Powered Aircraft - Ground-Air Commercial Occupant 841.5 = Oth & Unspec Powered Aircraft - Oth Powered Aircraft Occupant 841.6 = Oth & Unspec Powered Aircraft - Unpowered Aircraft Occupant 841.7 = Oth & Unspec Powered Aircraft - Parachutist 841.8 = Oth & Unspec Powered Aircraft - Ground Crew/Airline Employee 841.9 = Oth & Unspec Powered Aircraft - Oth Person 842.6 = Unpowered Aircraft - Unpowered Aircraft Occupant 842.7 = Unpowered Aircraft - Parachutist

Section	Screen	Data Element Description	Collector Data Name	Definition
				842.8 = Unpowered Aircraft - Ground Crew/Airline Employee 842.9 = Unpowered Aircraft - Oth Person 843.0 = Fall In/ On/ From Aircraft - Spacecraft Occupant 843.1 = Fall In/ On/ From Aircraft - Military Aircraft Occupant 843.2 = Fall In/ On/ From Aircraft - Ground-Ground Commercial Crew 843.3 = Fall In/ On/ From Aircraft - Ground-Ground Commercial Occupant 843.4 = Fall In/ On/ From Aircraft - Ground-Air Commercial Occupant 843.5 = Fall In/ On/ From Aircraft - Oth Powered Aircraft Occupant 843.6 = Fall In/ On/ From Aircraft - Unpowered Aircraft Occupant 843.7 = Fall In/ On/ From Aircraft - Parachutist 843.8 = Fall In/ On/ From Aircraft - Ground Crew/Airline Employee 843.9 = Fall In/ On/ From Aircraft - Oth Person 844.0 = Oth Spec Air Transport - Spacecraft Occupant 844.1 = Oth Spec Air Transport - Military Aircraft Occupant 844.2 = Oth Spec Air Transport - Ground-Ground Commercial Crew 844.3 = Oth Spec Air Transport - Ground-Ground Commercial Occupant 844.4 = Oth Spec Air Transport - Ground-Air Commercial Occupant 844.5 = Oth Spec Air Transport - Oth Powered Aircraft Occupant 844.6 = Oth Spec Air Transport - Unpowered Aircraft Occupant 844.7 = Oth Spec Air Transport - Parachutist 844.8 = Oth Spec Air Transport - Ground Crew/Airline Employee 844.9 = Oth Spec Air Transport - Oth Person 845.0 = Spacecraft Accident - Spacecraft Occupant 845.8 = Spacecraft Accident - Ground Crew/Airline Employee 845.9 = Spacecraft Accident - Oth Person **Vehicle Accidents Not Elsewhere Classifiable** 846.0 = Powered Veh w/in Premises of Industrial/Commercial Establishment 847.0 = Accidents Involving Cable Cars Not Running on Rails 848.0 = Accidents Involving Oth Veh, NEC **Accidental Poisioning by Drugs, Medicinal Substances, and Biologicals** 850.0 = Acc Poison - Heroin 850.1 = Acc Poison - Methadone 850.2 = Acc Poison - Oth Opiates and Related Narcotics 850.3 = Acc Poison - Salicylates 850.4 = Acc Poison - Aromatic Analgesics, NEC 850.5 = Acc Poison - Pyrazole Derivatives 850.6 = Acc Poison - Antirheumatics [antiphlogistics] 850.7 = Acc Poison - Oth Non-Narcotic Analgesics 850.8 = Acc Poison - Oth Spec Analgesics and Antipyretics 850.9 = Acc Poison - Unspec Analgesic or Antipyretic 851.0 = Acc Poison - Barbiturates 852.0 = Acc Poison - Chloral Hydrate Group 852.1 = Acc Poison - Paraldehyde 852.2 = Acc Poison - Bromine Compounds 852.3 = Acc Poison - Methaqualone Compounds 852.4 = Acc Poison - Glutethimide Group 852.5 = Acc Poison - Mixed Sedatives, NEC 852.8 = Acc Poison - Oth Spec Sedatives and Hypnotics 852.9 = Acc Poison - Unspec Sedative or Hypnotic 853.0 = Acc Poison - Phenothiazine-based Tranquilizers 853.1 = Acc Poison - Butyrophenone-based Tranquilizers 853.2 = Acc Poison - Benzodiazepine-based Tranquilizers 853.8 = Acc Poison - Oth Spec Tranquilizers 853.9 = Acc Poison - Unspec Tranquilizer 854.0 = Acc Poison - Antidepressants 854.1 = Acc Poison - Psychodysleptics [hallucinogens] 854.2 = Acc Poison - Psychostimulants 854.3 = Acc Poison - Central Nervous System Stimulants 854.8 = Acc Poison - Oth Psychotropic Agents

Section	Screen	Data Element Description	Collector Data Name	Definition
				855.0 = Acc Poison - Anticonvulsant & Anti-Parkinsonism Drugs 855.1 = Acc Poison - Oth Central Nervous System Depressants 855.2 = Acc Poison - Local Anesthetics 855.3 = Acc Poison - Parasympathomimetics [cholinergics] 855.4 = Acc Poison - Parasympatholytics/Spasmolytics 855.5 = Acc Poison - Sympathomimetics [adrenergics] 855.6 = Acc Poison - Sympatholytics [antiadrenergics] 855.8 = Acc Poison - Oth Spec Drugs on Central/Autonomic Nervous System 855.9 = Acc Poison - Unspec Drugs on Central/Autonomic Nervous System 856.0 = Acc Poison - Antibiotics 857.0 = Acc Poison - Oth Anti-Infectives 858.0 = Acc Poison - Hormones and Synthetic Substitutes 858.1 = Acc Poison - Primarily Systemic Agents 858.2 = Acc Poison - Agents Mainly Affecting Blood Constituents 858.3 = Acc Poison - Agents Mainly Affecting Cardiovascular System 858.4 = Acc Poison - Agents Mainly Affecting Gastrointestinal System 858.5 = Acc Poison - H2O/Mineral/Uric Acid Metabolism Drugs 858.6 = Acc Poison - Agents act on Smooth,Skeletal Muscles & Respiratory 858.7 = Acc Poison - Skin/Ophthalmological/Otorhinolaryngological/Dental 858.8 = Acc Poison - Oth Spec Drugs 858.9 = Acc Poison - Unspec Drug **Accidental Poisoning by Other Solid and Liquid Substances, Gases, And Vapors** 860.0 = Acc Poison - Alcoholic Beverages 860.1 = Acc Poison - Oth/Unspec Ethyl Alcohol and Its Products 860.2 = Acc Poison - Methyl Alcohol 860.3 = Acc Poison - Isopropyl Alcohol 860.4 = Acc Poison - Fusel Oil 860.8 = Acc Poison - Oth Spec Alcohols 860.9 = Acc Poison - Unspec Alcohol 861.0 = Acc Poison - Synthetic Detergents and Shampoos 861.1 = Acc Poison - Soap Products 861.2 = Acc Poison - Polishes 861.3 = Acc Poison - Oth Cleansing and Polishing Agents 861.4 = Acc Poison - Disinfectants 861.5 = Acc Poison - Lead Paints 861.6 = Acc Poison - Oth Paints and Varnishes 861.9 = Acc Poison - Unspec 862.0 = Acc Poison - Petroleum Solvents 862.1 = Acc Poison - Petroleum Fuels and Cleaners 862.2 = Acc Poison - Lubricating Oils 862.3 = Acc Poison - Petroleum Solids 862.4 = Acc Poison - Oth Spec Solvents 862.9 = Acc Poison - Unspec Solvent 863.0 = Acc Poison - Insecticides of Organochlorine Compounds 863.1 = Acc Poison - Insecticides of Organophosphorus Compounds 863.2 = Acc Poison - Carbamates 863.3 = Acc Poison - Mixtures of Insecticides 863.4 = Acc Poison - Oth and Unspec Insecticides 863.5 = Acc Poison - Herbicides 863.6 = Acc Poison - Fungicides 863.7 = Acc Poison - Rodenticides 863.8 = Acc Poison - Fumigants 863.9 = Acc Poison - Oth and Unspec 864.0 = Acc Poison - Corrosive Aromatics 864.1 = Acc Poison - Acids 864.2 = Acc Poison - Caustic Alkalis 864.3 = Acc Poison - Oth Spec Corrosives and Caustics 864.4 = Acc Poison - Unspec Corrosives and Caustics 865.0 = Acc Poison - Meat

Section	Screen	Data Element Description	Collector Data Name	Definition
				865.1 = Acc Poison - Shellfish 865.2 = Acc Poison - Oth Fish 865.3 = Acc Poison - Berries and Seeds 865.4 = Acc Poison - Oth Spec Plants 865.5 = Acc Poison - Mushrooms and Oth Fungi 865.8 = Acc Poison - Oth Spec Foods 865.9 = Acc Poison - Unspec Foodstuff or Poisonous Plant 866.0 = Acc Poison - Lead and Its Compounds and Fumes 866.1 = Acc Poison - Mercury and Its Compounds and Fumes 866.2 = Acc Poison - Antimony and Its Compounds and Fumes 866.3 = Acc Poison - Arsenic and Its Compounds and Fumes 866.4 = Acc Poison - Oth Metals and Their Compounds and Fumes 866.5 = Acc Poison - Plant Foods and Fertilizers 866.6 = Acc Poison - Glues and Adhesives 866.7 = Acc Poison - Cosmetics 866.8 = Acc Poison - Oth Spec Solid or Liquid Substances 866.9 = Acc Poison - Unspec Solid or Liquid Substance 867.0 = Acc Poison by Gas Distributed by Pipeline 868.0 = Acc Poison - Liquid Petroleum Gas in Mobile Containers 868.1 = Acc Poison - Oth and Unspec Utility Gas 868.2 = Acc Poison - Motor Veh Exhaust Gas 868.3 = Acc Poison - Carbon Monoxide-Incomplete Combustion Domestic Fuel 868.8 = Acc Poison - Carbon Monoxide From Oth Sources 868.9 = Acc Poison - Unspec Carbon Monoxide 869.0 = Acc Poison - Nitrogen Oxides 869.1 = Acc Poison - Sulfur Dioxide 869.2 = Acc Poison - Freon 869.3 = Acc Poison - Lacrimogenic Gas [tear gas] 869.4 = Acc Poison - Second Hand Tobacco Smoke 869.8 = Acc Poison - Oth Spec Gases and Vapors 869.9 = Acc Poison - Unspec Gases and Vapors **Misadventures to Patients During Surgical and Medical Care** 870.0 = Cut/Hemorrhage During - Surgical Operation 870.1 = Cut/Hemorrhage During - Infusion/Transfusion 870.2 = Cut/Hemorrhage During - Kidney Dialysis/Oth Perfusion 870.3 = Cut/Hemorrhage During - Injection/Vaccination 870.4 = Cut/Hemorrhage During - Endoscopic Examination 870.5 = Cut/Hemorrhage During - Aspiration/Puncture/Catheterization 870.6 = Cut/Hemorrhage During - Heart Catheterization 870.7 = Cut/Hemorrhage During - Administration of Enema 870.8 = Cut/Hemorrhage During - Oth Spec Medical Care 870.9 = Cut/Hemorrhage During - Unspec Medical Care 871.0 = Foreign Object Left In Body- Surgical Operation 871.1 = Foreign Object Left In Body- Infusion/Transfusion 871.2 = Foreign Object Left In Body- Kidney Dialysis/Oth Perfusion 871.3 = Foreign Object Left In Body- Injection/Vaccination 871.4 = Foreign Object Left In Body- Endoscopic Examination 871.5 = Foreign Object Left In Body- Aspiration/Puncture/Catheterization 871.6 = Foreign Object Left In Body- Heart Catheterization 871.7 = Foreign Object Left In Body- Removal of Catheter or Packing 871.8 = Foreign Object Left In Body- Oth Spec Procedures 871.9 = Foreign Object Left In Body- Unspec Procedure 872.0 = Sterile Precautions Fail - Surgical Operation 872.1 = Sterile Precautions Fail - Infusion/Transfusion 872.2 = Sterile Precautions Fail - Kidney Dialysis/Oth Perfusion 872.3 = Sterile Precautions Fail - Injection/Vaccination 872.4 = Sterile Precautions Fail - Endoscopic Examination 872.5 = Sterile Precautions Fail - Aspiration/Puncture/Catheterization 872.6 = Sterile Precautions Fail - Heart Catheterization

Section	Screen	Data Element Description	Collector Data Name	Definition
				872.8 = Sterile Precautions Fail - Oth Spec Procedures 872.9 = Sterile Precautions Fail - Unspec Procedure 873.0 = Dosage Fail - Excessive Blood/Fluid During (Trans/In)Fusion 873.1 = Dosage Fail - Incorrect Dilution of Fluid During Infusion 873.2 = Dosage Fail - Overdose of Radiation in Therapy 873.3 = Dosage Fail - Accidental Radiation Exposure During Care 873.4 = Dosage Fail - Dosage Fail in Electroshock/Insulin-Shock Therapy 873.5 = Dosage Fail - Inappropriate Temperature in Application/Packing 873.6 = Dosage Fail - Nonadministration of Necessary Drug/Medicine 873.8 = Dosage Fail - Oth Spec Dosage Fail 873.9 = Dosage Fail - Unspec Dosage Fail 874.0 = Instrument Mechanical Fail - Surgical Operation 874.1 = Instrument Mechanical Fail - Infusion/Transfusion 874.2 = Instrument Mechanical Fail - Kidney Dialysis/Oth Perfusion 874.3 = Instrument Mechanical Fail - Endoscopic Examination 874.4 = Instrument Mechanical Fail - Aspiration/Puncture/Catheterization 874.5 = Instrument Mechanical Fail - Heart Catheterization 874.8 = Instrument Mechanical Fail - Oth Spec Procedures 874.9 = Instrument Mechanical Fail - Unspec Procedure 875.0 = Contaminated Blood/Fluid/Drug/Bio Matter- Transfused/Infused 875.1 = Contaminated Blood/Fluid/Drug/Bio Matter- Injected/Vaccination 875.2 = Contaminated Blood/Fluid/Drug/Bio Matter- Administered,Oth Means 875.8 = Contaminated Blood/Fluid/Drug/Bio Matter- Oth 875.9 = Contaminated Blood/Fluid/Drug/Bio Matter- Unspec 876.0 = Oth Misadventures During - Mismatched Blood in Transfusion 876.1 = Oth Misadventures During - Wrong Fluid in Infusion 876.2 = Oth Misadventures During - Surgery Suture/Ligature Failure 876.3 = Oth Misadventures During - Endotracheal Tube Wrongly Placed 876.4 = Oth Misadventures During - Failure, Intro/Remove Oth Instrument 876.5 = Oth Misadventures During - Inappropriate Operation Performance 876.8 = Oth Misadventures - Oth Spec Misadventures During Care 876.9 = Oth Misadventures - Unspec Misadventures During Care **Surgical and Medical Procedures as the Cause of Abnormal Reaction of Patient or Later Complication, Without Mention of Misadventure at the Time Of Procedure** 878.0 = Surgery w/o Mention of Mishap - Transplant of Whole Organ 878.1 = Surgery w/o Mention of Mishap - Implant of Artificial Device 878.2 = Surgery w/o Mention of Mishap - Anastomosis/Bypass/Graft-Tissue 878.3 = Surgery w/o Mention of Mishap - Formation of External Stoma 878.4 = Surgery w/o Mention of Mishap - Oth Restorative Surgery 878.5 = Surgery w/o Mention of Mishap - Amputation of Limb(s) 878.6 = Surgery w/o Mention of Mishap - Removal of Oth Organ, Part/Total 878.8 = Surgery w/o Mention of Mishap - Oth Spec Surgery & Procedures 878.9 = Surgery w/o Mention of Mishap - Unspec Surgery & Procedures 879.0 = Oth Proc w/o Mention of Mishap - Cardiac Catheterization 879.1 = Oth Proc w/o Mention of Mishap - Kidney Dialysis 879.2 = Oth Proc w/o Mention of Mishap - Radiology/Radiotherapy 879.3 = Oth Proc w/o Mention of Mishap - Shock Therapy 879.4 = Oth Proc w/o Mention of Mishap - Aspiration of Fluid 879.5 = Oth Proc w/o Mention of Mishap - Insert Gastric/Duodenal Sound 879.6 = Oth Proc w/o Mention of Mishap - Urinary Catheterization 879.7 = Oth Proc w/o Mention of Mishap - Blood Sampling 879.8 = Oth Proc w/o Mention of Mishap - Oth Spec Procedures 879.9 = Oth Proc w/o Mention of Mishap - Unspec Procedure **Accidental Falls** 880.0 = Fall On or From Stairs/Steps - Escalator 880.1 = Fall On or From Stairs/Steps - Sidewalk Curb 880.9 = Fall On or From Stairs/Steps - Oth Stairs or Steps 881.0 = Fall On or From Ladders/Scaffolding - Ladder

Section	Screen	Data Element Description	Collector Data Name	Definition
				881.1 = Fall On or From Ladders/Scaffolding - Scaffolding 882.0 = Fall From or Out of Building/Other Structure 883.0 = Fall into Hole/Oth Surface Opening - Jump/Dive into H2O [pool] 883.1 = Fall into Hole/Oth Surface Opening - Well 883.2 = Fall into Hole/Oth Surface Opening - Storm Drain/Manhole 883.9 = Fall into Hole/Oth Surface Opening - Oth Hole/Surface Opening 884.0 = Oth Multi-level Fall - Playground Equipment 884.1 = Oth Multi-level Fall - Cliff 884.2 = Oth Multi-level Fall - Chair 884.3 = Oth Multi-level Fall - Wheechair 884.4 = Oth Multi-level Fall - Bed 884.5 = Oth Multi-level Fall - Other Furniture 884.6 = Oth Multi-level Fall - Commode Toilet 884.9 = Oth Multi-level Fall - Oth Multi-Level Fall 885.0 = Fall on Same Level - Nonmotorized Scooter 885.1 = Fall on Same Level - Roller/In-Line Skates 885.2 = Fall on Same Level - Skateboard 885.3 = Fall on Same Level - Skis 885.4 = Fall on Same Level - Snowboard 885.9 = Fall on Same Level - Other 886.0 = Fall From Collision/Push/Shoving By, W/ Oth Person - In Sports 886.9 = Fall From Collision/Push/Shoving By, W/ Oth Person - Oth/Unspec 887.0 = Fracture, Cause Unspec 888.0 = Oth and Unspec Fall - Resulting in Striking Sharp Object 888.1 = Oth and Unspec Fall - Resulting in Striking Other Object 888.8 = Oth and Unspec Fall - Oth 888.9 = Oth and Unspec Fall - Unspec **Accidents Caused by Fire and Flames** 890.0 = Private Dwelling Conflagration - Conflagration Explosion 890.1 = Private Dwelling Conflagration - Fumes from PVC Combustion 890.2 = Private Dwelling Conflagration - Oth Smoke and Fumes 890.3 = Private Dwelling Conflagration - Conflagration Burning 890.8 = Private Dwelling Conflagration - Oth Conflagration Accident 890.9 = Private Dwelling Conflagration - Unspec Conflagration Accident 891.0 = Oth/Unspec Building Conflagration- Conflagration Explosion 891.1 = Oth/Unspec Building Conflagration- Fumes from PVC Combustion 891.2 = Oth/Unspec Building Conflagration- Oth Smoke and Fumes 891.3 = Oth/Unspec Building Conflagration- Conflagration Burning 891.8 = Oth/Unspec Building Conflagration- Oth Conflagration Accident 891.9 = Oth/Unspec Building Conflagration- Unspec Conflagration Accident 892.0 = Conflagration Not in Building or Structure 893.0 = Clothing Ignition - Controlled Fire in Private Dwelling 893.1 = Clothing Ignition - Controlled Fire in Oth Building/Structure 893.2 = Clothing Ignition - Controlled Fire Not in Building/Structure 893.8 = Clothing Ignition - Oth Spec Sources 893.9 = Clothing Ignition - Unspec Source 894.0 = Ignition of Highly Inflammable Material 895.0 = Accident by Controlled Fire in Private Dwelling 896.0 = Accident by Controlled Fire in Oth/Unspec Building/Structure 897.0 = Accident by Controlled Fire Not in Building/Structure 898.0 = Accident by Oth Spec Fire and Flames - Burning Bedclothes 898.1 = Accident by Oth Spec Fire and Flames - Oth 899.0 = Accident by Unspec Fire **Accidents Due to Natural and Environmental Factors** 900.0 = Excessive Heat - Due to Weather Conditions 900.1 = Excessive Heat - Of Man-Made Origin 900.9 = Excessive Heat - Of Unspec Origin 901.0 = Excessive Cold - Due to Weather Conditions 901.1 = Excessive Cold - Of Man-Made Origin

Section	Screen	Data Element Description	Collector Data Name	Definition
				901.8 = Excessive Cold - Oth Spec Origin 901.9 = Excessive Cold - Of Unspec Origin 902.0 = High/Low/Changing Air Pressure - High Altitude Residence/Visit 902.1 = High/Low/Changing Air Pressure - In Aircraft 902.2 = High/Low/Changing Air Pressure - Due to Diving 902.8 = High/Low/Changing Air Pressure - Due to Oth Spec Causes 902.9 = High/Low/Changing Air Pressure - Unspec Cause 903.0 = Travel and Motion 904.0 = Hunger/Thirst/Exposure/Neglect - Infant/Helpless Persons 904.1 = Hunger/Thirst/Exposure/Neglect - Lack of Food 904.2 = Hunger/Thirst/Exposure/Neglect - Lack of H2O 904.3 = Hunger/Thirst/Exposure/Neglect - Exposure(to Weather), NEC 904.9 = Hunger/Thirst/Exposure/Neglect - Privation, Unqualified 905.0 = Poison/Toxic Reactions - Venomous Snakes/Lizards 905.1 = Poison/Toxic Reactions - Venomous Spiders 905.2 = Poison/Toxic Reactions - Scorpion 905.3 = Poison/Toxic Reactions - Hornets, Wasps, Bees 905.4 = Poison/Toxic Reactions - Centipede/Venomous Millipede (tropical) 905.5 = Poison/Toxic Reactions - Oth Venomous Arthropods 905.6 = Poison/Toxic Reactions - Venomous H2O Animals/Plants 905.7 = Poison/Toxic Reactions - Oth Plants 905.8 = Poison/Toxic Reactions - Oth Spec 905.9 = Poison/Toxic Reactions - Unspec 906.0 = Oth Injury by Animal - Dog Bite 906.1 = Oth Injury by Animal - Rat Bite 906.2 = Oth Injury by Animal - Bite of Nonvenomous Snakes/Lizards 906.3 = Oth Injury by Animal - Oth Animal Bite (Except Arthropod) 906.4 = Oth Injury by Animal - Bite of Nonvenomous Arthropod 906.5 = Oth Injury by Animal - Bite of Unspec Animal/Animal Bite NOS 906.8 = Oth Injury by Animal - Oth Spec Injury Caused by Animal 906.9 = Oth Injury by Animal - Unspec Injury Caused by Animal 907.0 = Lightning 908.0 = Cataclysmic Storms - Hurricane, Storm Surge, Tidal Wave, Typhoon 908.1 = Cataclysmic Storms - Tornado, Cyclone, Twisters 908.2 = Cataclysmic Storms - Floods, Torrential Rainfall, Flash Flood 908.3 = Cataclysmic Storms - Blizzard (snow/ice) 908.4 = Cataclysmic Storms - Dust Storm 908.8 = Cataclysmic Storms - Oth Cataclysmic Storms 908.9 = Cataclysmic Storms - Unspec Cataclysmic Storms/Storm NOS 909.0 = Cataclysmic Earth - Earthquakes 909.1 = Cataclysmic Earth - Volcanic Eruption, Burns from Lava/Ash Inhale 909.2 = Cataclysmic Earth - Avalanche, Landslide, Mudslide 909.3 = Cataclysmic Earth - Collapse of Dam or Made-made Structure 909.4 = Cataclysmic Earth - Tidal Wave, Tidal Wave NOS, Tsunami 909.8 = Cataclysmic Earth - Oth Cataclysmic Earth Movements/Eruptions 909.9 = Cataclysmic Earth - Unspec Cataclysmic Earth Movements/Eruptions **Accident Caused by Submersion, Suffocation, and Foreign Bodies** 910.0 = Accidental Drown/Submersion - While H2O-Skiing 910.1 = Accidental Drown/Submersion - Oth Sport w/ Diving Equipment 910.2 = Accidental Drown/Submersion - Oth Sport w/out Diving Equipment 910.3 = Accidental Drown/Submersion - Swim/Diving for Non-Sport Purposes 910.4 = Accidental Drown/Submersion - In Bathtub 910.8 = Accidental Drown/Submersion - Oth Accidental Drown/Submersion 910.9 = Accidental Drown/Submersion - Unspec Accidental Drown/Submersion 911.0 = Inhalation & Ingestion of Food Causing Choking/Suffocation 912.0 = Inhalation & Ingestion of Oth Object Causing Choking/Suffocation 913.0 = Accidental Mechanical Suffocate- In Bed or Cradle 913.1 = Accidental Mechanical Suffocate- By Plastic Bag 913.2 = Accidental Mechanical Suffocate- Lack of Air (In Closed Place)

Section	Screen	Data Element Description	Collector Data Name	Definition
				913.3 = Accidental Mechanical Suffocate- By Falling Earth/Oth Substance 913.8 = Accidental Mechanical Suffocate- Oth Spec Means 913.9 = Accidental Mechanical Suffocate- Unspec Means 914.0 = Foreign Body Accidentally Entering Eye and Adnexa 915.0 = Foreign Body Accidentally Entering Oth Orifice **Other Accidents** 916.0 = Struck Accidentally by Falling Object 917.0 = Striking Against/Struck Accidentally- In Sports w/o Subseq Fall 917.1 = Striking Against/Struck Accidentally- Crowd Fear/Panic w/o Subseq Fall 917.2 = Striking Against/Struck Accidentally- In Running H2O w/o Subseq Fall 917.3 = Striking Against/Struck Accidentally - Furniture w/o Subseq Fall 917.4 = Striking Against/Struck Accidentally - Oth Stationary Object w/o Subseq Fall 917.5 = Striking Against/Struck Accidentally - In Sports w/ Subseq Fall 917.6 = Striking Against/Struck Accidentally - Crowd, Collective Fear/Panic w/ Subseq Fall 917.7 = Striking Against/Struck Accidentally - Furniture w/ Subseq Fall 917.8 = Striking Against/Struck Accidentally - Oth Stationary Object w/ Subseq Fall 917.9 = Striking Against/Struck Accidentally- Oth w/ or w/o Subseq Fall 918.0 = Caught Accidentally In or Between Objects 919.0 = Machinery Accident - Agricultural Machines 919.1 = Machinery Accident - Mining and Earth-Drilling Machinery 919.2 = Machinery Accident - Lifting Machines and Appliances 919.3 = Machinery Accident - Metalworking Machines 919.4 = Machinery Accident - Woodworking and Forming Machines 919.5 = Machinery Accident - Prime Movers, Except Electrical Motors 919.6 = Machinery Accident - Transmission Machinery 919.7 = Machinery Accident - Earth Moving/Scraping/Oth Excavating Machine 919.8 = Machinery Accident - Oth Spec Machinery 919.9 = Machinery Accident - Unspec Machinery 920.0 = Cutting Object Accident - Powered Lawn Mower 920.1 = Cutting Object Accident - Oth Powered Hand Tools 920.2 = Cutting Object Accident - Powered Household Appliances/Implements 920.3 = Cutting Object Accident - Knives, Swords, and Daggers 920.4 = Cutting Object Accident - Oth Hand Tools and Implements 920.5 = Cutting Object Accident - Hypodermic Needle, Contaminated Needle 920.8 = Cutting Object Accident - Oth Spec Cut/Piercing Instrument/Object 920.9 = Cutting Object Accident - Unspec Cut/Piercing Instrument/Object 921.0 = Pressure Vessel Explosion Accident - Boilers 921.1 = Pressure Vessel Explosion Accident - Gas Cylinders 921.8 = Pressure Vessel Explosion Accident - Oth Spec Pressure Vessels 921.9 = Pressure Vessel Explosion Accident - Unspec Pressure Vessel 922.0 = Firearm Missile Accident - Handgun 922.1 = Firearm Missile Accident - Shotgun (Automatic) 922.2 = Firearm Missile Accident - Hunting Rifle 922.3 = Firearm Missile Accident - Military Firearms 922.4 = Firearm Missle Accident - Air Gun 922.5 = Firearm Missle Accident - Paintball Gun 922.8 = Firearm Missile Accident - Oth Spec Firearm Missile 922.9 = Firearm Missile Accident - Unspec Firearm Missile 923.0 = Explosive Material Accident - Fireworks 923.1 = Explosive Material Accident - Blasting Materials 923.2 = Explosive Material Accident - Explosive Gases 923.8 = Explosive Material Accident - Oth Explosive Materials 923.9 = Explosive Material Accident - Unspec Explosive Material 924.0 = Accident, Hot/Corrosive Material - Hot Liquids/Vapors/Steam 924.1 = Accident, Hot/Corrosive Material - Caustic/Corrosive Substances 924.2 = Accident, Hot/Corrosive Material - Hot (Boiling) Tap Water

Section	Screen	Data Element Description	Collector Data Name	Definition
				924.8 = Accident, Hot/Corrosive Material - Oth 924.9 = Accident, Hot/Corrosive Material - Unspec 925.0 = Accident, Electric Current - Domestic Wiring and Appliances 925.1 = Accident, Electric Current - Electric Power Plants/Stations/Lines 925.2 = Accident, Electric Current - Industrial Wires/Appliance/Machinery 925.8 = Accident, Electric Current - Oth Electric Current 925.9 = Accident, Electric Current - Unspec Electric Current 926.0 = Radiation Exposure - Radiofrequency Radiation 926.1 = Radiation Exposure - Infra-red Heaters and Lamps 926.2 = Radiation Exposure - Visible/Ultraviolet Light Sources 926.3 = Radiation Exposure - X-ray/Oth Electromagnetic Ionize Radiation 926.4 = Radiation Exposure - Lasers 926.5 = Radiation Exposure - Radioactive Isotopes 926.8 = Radiation Exposure - Oth Spec Radiation 926.9 = Radiation Exposure - Unspec Radiation 927.0 = Overexertion and Strenuous Movements 928.0 = Oth/Unspec Environmental/Accidental - Stay in Weightless Environment 928.1 = Oth/Unspec Environmental/Accidental - Exposure to Noise 928.2 = Oth/Unspec Environmental/Accidental - Vibration 928.3 = Oth/Unspec Environmental/Accidental - Human Being Bite 928.4 = Oth/Unspec Environmental/Accidental - External Constriction Caused by Hair 928.5 = Oth/Unspec Environmental/Accidental - External Constriction Caused by Other Obj 928.8 = Oth/Unspec Environmental/Accidental - Oth 928.9 = Oth/Unspec Environmental/Accidental - Unspec Accident **Late Effects and Adverse Effects Injury** 929.0 = Late Effects of Injury – MVA 929.1 = Late Effects of Injury - Oth Transport Accident
				929.2 = Late Effects of Injury - Accidental Poison 929.3 = Late Effects of Injury - Accidental Fall 929.4 = Late Effects of Injury - Accident Caused by Fire 929.5 = Late Effects of Injury - Accident by Natural/Environment Factors 929.8 = Late Effects of Injury - Oth Accidents 929.9 = Late Effects of Injury - Unspec Accident 930.0 = Adverse Effects - Penicillins 930.1 = Adverse Effects - Antifungal Antibiotics 930.2 = Adverse Effects - Chloramphenicol Group 930.3 = Adverse Effects - Erythromycin and Oth Macrolides 930.4 = Adverse Effects - Tetracycline Group 930.5 = Adverse Effects - Cephalosporin Group 930.6 = Adverse Effects - Antimycobacterial Antibiotics 930.7 = Adverse Effects - Antineoplastic Antibiotics 930.8 = Adverse Effects - Oth Spec Antibiotics 930.9 = Adverse Effects - Unspec Antibiotics 931.0 = Adverse Effects - Sulfonamides 931.1 = Adverse Effects - Arsenical Anti-Infectives 931.2 = Adverse Effects - Heavy Metal Anti-Infectives 931.3 = Adverse Effects - Quinoline/Hydroxyquinoline Derivatives 931.4 = Adverse Effects - Antimalarial/Drug Act on Oth Blood Protozoa 931.5 = Adverse Effects - Oth Antiprotozoal Drugs 931.6 = Adverse Effects - Anthelmintics 931.7 = Adverse Effects - Antiviral Drugs 931.8 = Adverse Effects - Oth Antimycobacterial Drugs 931.9 = Adverse Effects - Oth and Unspec Anti-Infectives 932.0 = Adverse Effects - Adrenal Cortical Steriods 932.1 = Adverse Effects - Androgens/Anabolic Cogeners 932.2 = Adverse Effects - Ovarian Hormone/Synthetic Substitutes 932.3 = Adverse Effects - Insulins/Antidiabetic Agents

Section	Screen	Data Element Description	Collector Data Name	Definition
				932.4 = Adverse Effects - Anterior Pituitary Hormones 932.5 = Adverse Effects - Posterior Pituitary Hormones 932.6 = Adverse Effects - Parathyroid/Parathyroid Derivatives 932.7 = Adverse Effects - Thyroid/Thyroid Derivatives 932.8 = Adverse Effects - Antithyroid Agents 932.9 = Adverse Effects - Oth/Unspec Hormones/Synthetic Substitutes 933.0 = Adverse Effects - Antiallergic/Antiemetic Drugs 933.1 = Adverse Effects - Antineoplastic/Immunosuppressive Drugs 933.2 = Adverse Effects - Acidifying Agents 933.3 = Adverse Effects - Alkalizing Agents 933.4 = Adverse Effects - Enzymes, NEC 933.5 = Adverse Effects - Vitamins, NEC 933.8 = Adverse Effects - Oth Systemic Agents, NEC 933.9 = Adverse Effects - Unspec Systemic Agent 934.0 = Adverse Effects - Iron and its Compounds 934.1 = Adverse Effects - Liver Preparations/Oth Antianemic Agent 934.2 = Adverse Effects - Anticoagulants 934.3 = Adverse Effects - Vitamin K [Phytonadione] 934.4 = Adverse Effects - Fibrinolysis-Affecting Drugs 934.5 = Adverse Effects - Anticoagulant Antagonists & Oth Coagulants 934.6 = Adverse Effects - Gamma Globulin 934.7 = Adverse Effects - Natural Blood/Blood Products 934.8 = Adverse Effects - Oth Agents Affecting Blood Constituents 934.9 = Adverse Effects - Unspec Agent Affecting Blood Constituents 935.0 = Adverse Effects - Heroin 935.1 = Adverse Effects - Methadone 935.2 = Adverse Effects - Oth Opiates & Related Narcotics 935.3 = Adverse Effects - Salicylates 935.4 = Adverse Effects - Aromatic Analgesics, NEC 935.5 = Adverse Effects - Pyrazole Derivatives 935.6 = Adverse Effects - Antirheumatics [Antiphlogistics] 935.7 = Adverse Effects - Oth Non-Narcotic Analgesics 935.8 = Adverse Effects - Oth Spec Analgesics/Antipyretics 935.9 = Adverse Effects - Unspec Analgesic/Antipyretic 936.0 = Adverse Effects - Oxazolidine Derivatives 936.1 = Adverse Effects - Hydantoin Derivatives 936.2 = Adverse Effects - Succinimides 936.3 = Adverse Effetcs - Oth/Unspec Anticonvulsants 936.4 = Adverse Effects - Anti-Parkinsonism Drugs 937.0 = Adverse Effects - Barbiturates 937.1 = Adverse Effects - Chloral Hydrate Group 937.2 = Adverse Effects - Paraldehyde 937.3 = Adverse Effects - Bromine Compounds 937.4 = Adverse Effects - Methaqualone Compounds 937.5 = Adverse Effects - Glutethimede Group 937.6 = Adverse Effects - Mixed Sedatives, NEC 937.8 = Adverse Effects - Oth Sedatives/Hypnotics 937.9 = Adverse Effects - Unspec 938.0 = Adverse Effects - Central Nervous System Muscle-Tone Depressants 938.1 = Adverse Effects - Halothane 938.2 = Adverse Effects - Oth Gaseous Anesthetics 938.3 = Adverse Effects - Intravenous Anesthetics 938.4 = Adverse Effects - Oth/Unspec General Anesthetics 938.5 = Adverse Effects - Surface/Infiltration Anesthetics 938.6 = Adverse Effects - Peripheral Nerve & Plexus-Blocking Anesthetics 938.7 = Adverse Effects - Spinal Anesthetics 938.9 = Adverse Effects - Oth/Unspec Local Anesthetics 939.0 = Adverse Effects - Antidepressants 939.1 = Adverse Effects - Phenothiazine-Based Tranquilizers 939.2 = Adverse Effects - Butyrophenone-Based Tranquilizers 939.3 = Adverse Effects - Oth Antipsychotic/Neuroleptic/Maj Tranquilizer

Section	Screen	Data Element Description	Collector Data Name	Definition
				939.4 = Adverse Effects - Benzodiazepine-Based Tranquilizers 939.5 = Adverse Effects - Oth Tranquilizers 939.6 = Adverse Effects - Psychodysleptics [hallucinogens] 939.7 = Adverse Effects - Psychostimulants 939.8 = Adverse Effects - Oth Psychotropic Agents 939.9 = Adverse Effects - Unspec Psychotropic Agent 940.0 = Adverse Effects - Analeptics 940.1 = Adverse Effects - Opiate Antagonists 940.8 = Adverse Effects - Oth Spec Central Nervous System Stimulants 940.9 = Adverse Effects - Unspec Central Nervous System Stimulant 941.0 = Adverse Effects - Parasympathomimetics [cholinergics] 941.1 = Adverse Effects - Parasympathomimetics/Spasmolytics 941.2 = Adverse Effects - Sympathomimetics [adrenergics] 941.3 = Adverse Effects - Sympatholytics [antiadrenergics] 941.9 = Adverse Effects - Unspec Drug Affecting Autonomic Nervous System 942.0 = Adverse Effects - Cardiac Rhythm Regulators 942.1 = Adverse Effects - Cardiotonic Glycosides/Similar Drugs 942.2 = Adverse Effects - Antilipemic/Antiarteriosclerotic Drugs 942.3 = Adverse Effects - Ganglion-Blocking Agents 942.4 = Adverse Effects - Coronary Vasodilators 942.5 = Adverse Effects - Oth Vasodilators 942.6 = Adverse Effects - Oth Antihypertensive Agents 942.7 = Adverse Effects - Antivaricose Drugs/Sclerosing Agents 942.8 = Adverse Effects - Capillary-Active Drugs 942.9 = Adverse Effects - Oth & Unspec Agents on Cardiovascular System 943.0 = Adverse Effects - Antacids/Antigastric Secretion Drugs 943.1 = Adverse Effects - Irritant Cathartics 943.2 = Adverse Effects - Emollient Cathartics 943.3 = Adverse Effects - Oth Cathartic/Intestinal Atonia Drugs 943.4 = Adverse Effects - Digestants 943.5 = Adverse Effects - Antidiarrheal Drugs 943.6 = Adverse Effects - Emetics 943.8 = Adverse Effects - Oth Spec Agents on Gastrointestinal System 943.9 = Adverse Effects - Unspec Agent on Gastrointestinal System 944.0 = Adverse Effects - Mercurial Diuretics 944.1 = Adverse Effects - Purine Derivative Diuretics 944.2 = Adverse Effects - Carbon Acid Anhydrase Inhibitors 944.3 = Adverse Effects - Saluretics 944.4 = Adverse Effects - Oth Diuretics 944.5 = Adverse Effects - Electrolytic, Caloric, H2O-Balance Agents 944.6 = Adverse Effects - Oth Mineral Salts, NEC 944.7 = Adverse Effects - Uric Acid Metabolism Drugs 945.0 = Adverse Effects - Oxytocic Agents 945.1 = Adverse Effects - Smooth Muscle Relaxants 945.2 = Adverse Effects - Skeletal Muscle Relaxants 945.3 = Adverse Effects - Oth & Unspec Drugs Acting on Muscles 945.4 = Adverse Effects - Antitussives 945.5 = Adverse Effects - Expectorants 945.6 = Adverse Effects - Anti-Common Cold Drugs 945.7 = Adverse Effects - Antiasthmatics 945.8 = Adverse Effects - Oth & Unspec Respiratory Drugs 946.0 = Adverse Effects - Local Anti-Infectives & Anti-Inflammatory Drug 946.1 = Adverse Effects - Antipruritics 946.2 = Adverse Effects - Local Astringents & Local Detergents 946.3 = Adverse Effects - Emollients, Demulcents, and Protectants 946.4 = Adverse Effects - Keratolytics, Keratoplastics, Hair Treatments 946.5 = Adverse Effects - Eye Anti-Infectives and Oth Eye Drugs 946.6 = Adverse Effects - Anti-Infectives/Oth Drugs for Ear/Nose/Throat 946.7 = Adverse Effects - Dental Drugs Topically Applied 946.8 = Adverse Effects - Oth Agents Affecting Skin & Mucous Membrane 946.9 = Adverse Effects - Unspec Agent Affecting Skin & Mucous Membrane

Section	Screen	Data Element Description	Collector Data Name	Definition
				947.0 = Adverse Effects - Dietetics 947.1 = Adverse Effects - Lipotropic Drugs 947.2 = Adverse Effects - Antidotes & Chelating Agents, NEC 947.3 = Adverse Effects - Alcohol Deterrents 947.4 = Adverse Effects - Pharmaceutical Excipients 947.8 = Adverse Effects - Oth Drugs & Medicinal Substances 947.9 = Adverse Effects - Unspec Drug or Medicinal Substance 948.0 = Adverse Effects - BCG Vaccine 948.1 = Adverse Effects - Typhoid and Paratyphoid 948.2 = Adverse Effects - Cholera 948.3 = Adverse Effects - Plague 948.4 = Adverse Effects - Tetanus 948.5 = Adverse Effects - Diphtheria 948.6 = Adverse Effects - Pertussis Vaccine, Pertussis Component Combo 948.8 = Adverse Effects - Oth and Unspec Bacterial Vaccines 948.9 = Adverse Effects - Mixed Bacterial Vaccines,No Pertusis Component 949.0 = Adverse Effects - Smallpox Vaccine 949.1 = Adverse Effects - Rabies Vaccine 949.2 = Adverse Effects - Typhus Vaccine 949.3 = Adverse Effects - Yellow Fever Vaccine 949.4 = Adverse Effects - Measles Vaccine 949.5 = Adverse Effects - Poliomyelitis Vaccine 949.6 = Adverse Effects - Oth & Unspec Viral & Rickettsial Vaccines 949.7 = Adverse Effects - Mixed Viral-Rickettsial & Bacterial Vaccines 949.9 = Adverse Effects - Oth & Unspec Vaccines & Biological Substances **Suicide and Self-Inflicted Injury** 950.0 = Suicide/Self Poison- Analgesics, Antipyretics & Antirheumatics 950.1 = Suicide/Self Poison- Barbiturates 950.2 = Suicide/Self Poison- Oth Sedatives & Hypnotics 950.3 = Suicide/Self Poison- Tranquilizers/Oth Psychotropic Agents 950.4 = Suicide/Self Poison- Oth Spec Drugs/Medicinal Substances 950.5 = Suicide/Self Poison- Unspec Drug/Medicinal Substance 950.6 = Suicide/Self Poison- (Agri/Horti)Cultural Chemical/Pharmaceutical 950.7 = Suicide/Self Poison- Corrosive/Caustic Substances 950.8 = Suicide/Self Poison- Arsenic and its Compounds 950.9 = Suicide/Self Poison- Oth & Unspec Solid/Liquid Substances 951.0 = Suicide/Self Poison - Gas Distributed by Pipeline 951.1 = Suicide/Self Poison - Liquid Petroleum Gas (Mobile Containers) 951.8 = Suicide/Self Poison - Oth Utility Gas 952.0 = Suicide/Self Poison - Motor Vehicle Exhaust Gas 952.1 = Suicide/Self Poison - Oth Carbon Monoxide 952.8 = Suicide/Self Poison - Oth Spec Gases and Vapors 952.9 = Suicide/Self Poison - Unspec Gases and Vapors 953.0 = Suicide/Self Injury - Hanging 953.1 = Suicide/Self Injury - Suffocation by Plastic Bag 953.8 = Suicide/Self Injury - Oth Spec Means 953.9 = Suicide/Self Injury - Unspec Means 954.0 = Suicide and Self-Inflicted Injury by Submersion [Drowning] 955.0 = Suicide/Self Injury - Handgun 955.1 = Suicide/Self Injury - Shotgun 955.2 = Suicide/Self Injury - Hunting Rifle 955.3 = Suicide/Self Injury - Military Firearms 955.4 = Suicide/Self Injury - Oth and Unspec Firearm 955.5 = Suicide/Self Injury - Explosives 955.6 = Suicide/Self Injury - Air Gun 955.7 = Suicide/Self Injury - Paintball Gun 955.9 = Suicide/Self Injury - Unspec 956.0 = Suicide and Self-Inflicted Injury by Cut/Piercing Instrument 957.0 = Suicide/Self Injury, Jump,High Place - Residential Premises 957.1 = Suicide/Self Injury, Jump,High Place - Oth Man-Made Structures

Section	Screen	Data Element Description	Collector Data Name	Definition
				957.2 = Suicide/Self Injury, Jump,High Place - Natural Sites 957.9 = Suicide/Self Injury, Jump,High Place - Unspec 958.0 = Suicide/Self Injury - Jumping or Lying Before Moving Object 958.1 = Suicide/Self Injury - Burns, Fire 958.2 = Suicide/Self Injury - Scald 958.3 = Suicide/Self Injury - Extremes of Cold 958.4 = Suicide/Self Injury - Electrocution 958.5 = Suicide/Self Injury - Crashing of Motor Vehicle 958.6 = Suicide/Self Injury - Crashing of Aircraft 958.7 = Suicide/Self Injury - Caustic Substances, Except Poisoning 958.8 = Suicide/Self Injury - Oth Spec Means 958.9 = Suicide/Self Injury - Unspec Means 959.0 = Late Effects of Self-Inflicted Injury **Homicide and Injury Purposely Inflicted by Other Persons** 960.0 = Fight/Brawl/Rape - Unarmed Fight or Brawl 960.1 = Fight/Brawl/Rape - Rape 961.0 = Assault by Corrosive or Caustic Substance, Except Poisoning 962.0 = Assault by Poison - Drugs and Medicinal Substances 962.1 = Assault by Poison - Oth Solid and Liquid Substances 962.2 = Assault by Poison - Oth Gases and Vapors 962.9 = Assault by Poison - Unspec Poisoning 963.0 = Assault by Hanging and Strangulation 964.0 = Assault by Submersion [Drowning] 965.0 = Assault by Firearms/Explosives - Handgun 965.1 = Assault by Firearms/Explosives - Shotgun 965.2 = Assault by Firearms/Explosives - Hunting Rifle 965.3 = Assault by Firearms/Explosives - Military Firearms 965.4 = Assault by Firearms/Explosives - Oth and Unspec Firearm 965.5 = Assault by Firearms/Explosives - Antipersonnel Bomb 965.6 = Assault by Firearms/Explosives - Gasoline Bomb 965.7 = Assault by Firearms/Explosives - Letter Bomb 965.8 = Assault by Firearms/Explosives - Oth Spec Explosive 965.9 = Assault by Firearms/Explosives - Unspec Explosive 966.0 = Assault by Cutting and Piercing Instrument 967.0 = Child/Adult Abuse - Father/Stepfather/Male Partner 967.1 = Child/Adult Abuse - Oth Spec Person 967.2 = Child/Adult Abuse - Mother/Stepmother/Female Partner 967.3 = Child/Adult Abuse - Spouse/Partner/Ex-Spouse/Ex-Partner 967.4 = Child/Adult Abuse - Child 967.5 = Child/Adult Abuse - Sibling 967.6 = Child/Adult Abuse - Grandparent 967.7 = Child/Adult Abuse - Other Relative 967.8 = Child/Adult Abuse - Non-related Caregiver 967.9 = Child/Adult Abuse - Unspec Person 968.0 = Assault by Oth/Unspec Means - Fire 968.1 = Assault by Oth/Unspec Means - Pushing from a High Place 968.2 = Assault by Oth/Unspec Means - Striking by Blunt/Thrown Object 968.3 = Assault by Oth/Unspec Means - Hot Liquid 968.4 = Assault by Oth/Unspec Means - Criminal Neglect 968.5 = Assault by Oth/Unspec Means - Vehicular Assault 968.6 = Assault by Oth/Unspec Means - Air Gun 968.7 = Assault by Oth/Unspec Means - Human Being Bite 968.8 = Assault by Oth/Unspec Means - Oth Spec Means 968.9 = Assault by Oth/Unspec Means - Unspec Means 969.0 = Late Effects of Injury Purposely Inflicted by Oth Person **Legal Intervention** 970.0 = Injury Due to Legal Intervention by Firearms 971.0 = Injury Due to Legal Intervention by Explosives 972.0 = Injury Due to Legal Intervention by Gas

Section	Screen	Data Element Description	Collector Data Name	Definition
				973.0 = Injury Due to Legal Intervention by Blunt Object 974.0 = Injury Due to Legal Intervention by Cut/Piercing Instrument 975.0 = Injury Due to Legal Intervention by Oth Spec Means 976.0 = Injury Due to Legal Intervention by Unspec Means 977.0 = Late Effects of Injuries Due to Legal Intervention 978.0 = Legal Execution **Injury Resulting From Terrorism** 979.0 = Terrorism - Explosion or Marine Weapons 979.1 = Terrorism - Destruction of Aircraft 979.2 = Terrorism - Other Explosions and Fragments 979.3 = Terrorism - Fires, Conflagration and Hot Substances 979.4 = Terrorism - Firearms 979.5 = Terrorism - Nuclear Weapons 979.6 = Terrorism - Biological Weapons 979.7 = Terrorism - Chemical Weapons 979.8 = Terrorism - Other Weapons 979.9 = Terrorism - Secondary Effects **Injury Undetermined Whether Accidentally or Purposely Inflicted** 980.0 = Poison,Un/Intentional- Analgesic/Anti(Pyretic/Rheumatic) 980.1 = Poison,Un/Intentional- Barbiturates 980.2 = Poison,Un/Intentional- Oth Sedatives and Hypnotics 980.3 = Poison,Un/Intentional- Tranquilizers/Psychotropic Agents 980.4 = Poison,Un/Intentional- Oth Spec Drugs/Medicines 980.5 = Poison,Un/Intentional- Unspec Drug/Medicine 980.6 = Poison,Un/Intentional- Corrosive/Caustic Substances 980.7 = Poison,Un/Intentional- (Agri/Horti)Cultural Chemical/Pharmaceutic 980.8 = Poison,Un/Intentional- Arsenic and its Compounds 980.9 = Poison,Un/Intentional- Oth/Unspec Solids/Liquids 981.0 = Poison, Un/Intentional - Gas Distributed by Pipeline 981.1 = Poison, Un/Intentional - Liquid Petroleum Gas (Mobile Containers) 981.8 = Poison, Un/Intentional - Oth Utility Gas 982.0 = Poison, Un/Intentional - Motor Vehicle Exhaust Gas 982.1 = Poison, Un/Intentional - Oth Carbon Monoxide 982.8 = Poison, Un/Intentional - Oth Spec Gases and Vapors 982.9 = Poison, Un/Intentional - Unspec Gases and Vapors 983.0 = Hang/Strangle/Suffocate, Un/Intentional- Hanging 983.1 = Hang/Strangle/Suffocate, Un/Intentional- Suffocate by Plastic Bag 983.8 = Hang/Strangle/Suffocate, Un/Intentional- Oth Spec Means 983.9 = Hang/Strangle/Suffocate, Un/Intentional- Unspec Means 984.0 = Submersion [Drowning], Undetermined Un/Intentional 985.0 = Firearms/Explosives, Un/Intentional - Handgun 985.1 = Firearms/Explosives, Un/Intentional - Shotgun 985.2 = Firearms/Explosives, Un/Intentional - Hunting Rifle 985.3 = Firearms/Explosives, Un/Intentional - Military Firearms 985.4 = Firearms/Explosives, Un/Intentional - Oth/Unspec Firearm 985.5 = Firearms/Explosives, Un/Intentional - Explosives 985.6 = Firearms/Explosives, Un/Intentional - Air Gun 985.7 = Firearms/Explosives, Un/Intentional - Paintball Gun 986.0 = Injury by Cut/Piercing Instruments, Undetermined Un/Intentional 987.0 = Fall From High Place, Un/Intentional - Residential Premises 987.1 = Fall From High Place, Un/Intentional - Oth Man-Made Structures 987.2 = Fall From High Place, Un/Intentional - Natural Sites 987.9 = Fall From High Place, Un/Intentional - Unspec Site 988.0 = Oth/Unspec Injury, Un/Intentional - Jump/Lie Before Moving Object 988.1 = Oth/Unspec Injury, Un/Intentional - Burns/Fire 988.2 = Oth/Unspec Injury, Un/Intentional - Scald 988.3 = Oth/Unspec Injury, Un/Intentional - Extremes of Cold 988.4 = Oth/Unspec Injury, Un/Intentional - Electrocution 988.5 = Oth/Unspec Injury, Un/Intentional - Crashing of Motor Vehicle

Section	Screen	Data Element Description	Collector Data Name	Definition
				988.6 = Oth/Unspec Injury, Un/Intentional - Crashing of Aircraft 988.7 = Oth/Unspec Injury, Un/Intentional - Caustic Substances,Not Poison 988.8 = Oth/Unspec Injury, Un/Intentional - Oth Spec Means 988.9 = Oth/Unspec Injury, Un/Intentional - Unspec Means 989.0 = Late Effects of Injury, Undetermined Un/Intentional **Injury Resulting From Operations of War** 990.0 = War Operations Injury - From Gasoline Bomb 990.9 = War Operations Injury - From Oth/Unspec Source 991.0 = War Operations Injury - Rubber Bullets (Rifle) 991.1 = War Operations Injury - Pellets (Rifle) 991.2 = War Operations Injury - Oth Bullets 991.3 = War Operations Injury - Antipersonnel Bomb (Fragments) 991.9 = War Operations Injury - Oth/Unspec Fragments 992.0 = Injury Due to War Operations by Explosion of Marine Weapons 993.0 = Injury Due to War Operations by Oth Explosion 994.0 = Injury Due to War Operations by Destruction of Aircraft 995.0 = Injury Due to War Operations by Oth/Unspec Conventional Warfare 996.0 = Injury Due to War Operations by Nuclear Weapons 997.0 = War Operations Injury - Lasers 997.1 = War Operations Injury - Biological Warfare 997.2 = War Operations Injury - Gases, Fumes, and Chemicals 997.8 = War Operations Injury - Oth Spec Unconventional Warfare 997.9 = War Operations Injury - Unspec Unconventional Warfare 998.0 = Injury Due to War Operations but Occur After Hostile Cessation 999.0 = Late Effect of Injury Due to War Operations 999.1 = Late Effect of Injury Due to Terrorism
Injury Data	F2.2	Specify	CAUSE_INJ1	Written description of primary cause of injury (see E_CODE).
Injury Data	F2.2	Secondary E-Code	E_CODE_2	Secondary E-Code using standard ICD-9-CM E-Codes. See the primary E-Code (E_CODE) for values. Examples: • A car crash resulting in a fire • A car crash where the car ends submerged in water • A house fire where the victim jumps out of a window. The registrar will need to determine the primary cause (most important cause of this hospitalization) and the secondary cause.
Injury Data	F2.2	Specify	CAUSE_INJ2	Written description of secondary cause of injury (see E_CODE_2).
Injury Data	F2.2	Type of Injury	**BLUNT_PENT**	The type of *force* that caused the injury. If there was more than one cause, choose the one which caused the more severe injury. Note: Be sure to record the *force* of the injury, not the type of injury (e.g. a blunt trauma MVA could be the cause (force) of an open fracture (type of injury)). 1 = Blunt 2 = Penetrating 3 = Other (e.g. burns, near-drowning, asphyxiation, electrocution, foreign-body obstruction, etc.)
Injury Data	F2.2	Mechanism of Injury	**MECH_INJ**	Note: The following non-trauma Prehospital Codes should not be used in the Registry as trauma mechanisms: AD, AL, AX, DT, MD, OB, OD, PS, SX, XX Mechanism of Injury AC = Other Accident or Injury (Note: if AC is chosen, please describe the injury in the field for mechanism of injury if Other (MECH_INJ_O)) AN = Animal Caused Injury AS = Beating, Fight, or Assault without weapon BI = Bicycle (including Bicycle vs. Car)

Section	Screen	Data Element Description	Collector Data Name	Definition
				BL = Blunt Instrument BU = Burn CH = Child Abuse DR = Drowning ES = Electrical Shock or Explosion FA = Fall GS = Firearms (gunshot) KN = Sharp Instrument (knife) MC = Motorcycle (including Motorcycle vs. Car) ME = Machinery or Equipment MV = Motor Vehicle PV = Pedestrian vs. Vehicle SP = Sports or Play Injury ST = Strangulation or Suffocation Note: Enter "*" for unknown. Do not enter "I" or "U".
Injury Data	F2.2	If Other	MECH_INJ_O	Written description of injury if AC was chosen as the mechanism of injury (see MECH_INJ).
Injury Data	F2.2	Work Related	**WORK_RELAT**	Work related injury as documented in the patient's medical record? 1 = yes 2 = no
Injury Data	F2.2	Protective Device	**PROT_DEV_1**	The first (of two) most important device in use by this patient, including injury prevention devices used in sports, industry, non-motorized and motorized vehicles, or at home. Enter 00=None if the appropriate mechanism is applicable but either the EMS or Hospital record explicitly states that the device was not used. e.g., the mechanism is a drowning or near-drowning and the patient was *not* wearing a personal flotation device. For this same example, enter 'Unknown' if the patient record doesn't indicate whether the patient was wearing a PFD. Enter 'Inappropriate' if the incident wasn't an MVA (including motorcycle), a boating accident, a firearm accident, or a non-motorized vehicle accident (such as bicycle, skateboard, in-line skates, scooter, etc.). 00 = None 01 = Lap Belt 02 = Shoulder Belt 03 = Lap/Shoulder Belt Combined 04 = Safety Belt, unspecified type 05 = Airbag only 06 = Airbag/Belt 07 = Helmet 08 = Infant/Child Booster Seat 09 = Other 10 = Personal Flotation Device (PFD) 11 = Gunlock or Lockbox
Injury Data	F2.2	Protective Device	**PROT_DEV_2**	The second most important device as described in PROT_DEV_1.
Injury Data	F2.2	If Other	PROT_DEV_O	Description of the protective device if 'Other' (=9) was chosen for either protective device 1 or 2. (see PROT_DEV_1 & PROT_DEV_2)
Injury Data	F2.3	Injury Memo	NOTES_INJ	Ten lines designated for a description of patient's injury.
Pre-H/Transfer	F3.1	Transport Mode	**TRANSP_S**	How the patient was transported from the scene/field. *Note that "transport" refers to the unit that provides most of the transportation between the scene and the receiving facility.* 1 = Ground Ambulance (Pre-Hospital Agency)

Section	Screen	Data Element Description	Collector Data Name	Definition
				2 = Helicopter (Pre-Hospital Agency) 3 = Fixed Wing Aircraft (Pre-Hospital Agency) 4 = Police (or other Law Enforcement, not a Pre-Hospital agency) 5 = Private Vehicle (not a Pre-Hospital agency) 6 = Other
Pre-H/Transfer	F3.1	First-On-Scene ID #	**FIRST_AG**	The Agency Identification Number of the first licensed EMS agency at the scene. The menu is user-defined. The format for the Agency ID Number is NNXNN: 2 numbers indicating the county, 1 alpha indicating the type of agency, and 2 numbers indicating the district. Please refer to the Washington State Department of Health's EMS Licensed Prehospital Service Listing for applicable agency ID numbers. Note: First-on-Scene ID now skipped for non-EMS Transport Modes.
Pre-H/Transfer	F3.1	Level of Transport Personnel	**LEV_SERV**	The *highest level of certification of personne*l from the primary transporting agency on this run. 1 = Advanced Life Support (ALS) -- Paramedic, RN, MD 2 = Intermediate Life Support (ILS) -- IV Tech, Airway Tech, IV/Airway Tech 3 = Basic Life Support (BLS) -- Advanced First Aid, First Responder, EMT
Pre-H/Transfer	F3.1	Transport Agency ID #	**TRANSP_AG**	The ID (license) number of the primary transport agency. Note: "Primary transport" refers to the unit which provides *most* of the medical care between the scene and the receiving facility. *Example: A helicopter transports a patient from a wilderness scene to a landing site a few blocks from an urban trauma center. The patient is transported the last few blocks by ground ambulance. The **air ambulance** (helicopter) is the **prImary** transportation.*
Pre-H/Transfer	F3.1	Unit #	**TRANSP_UN**	Identifies the number of the unit (vehicle) that transported the patient. This is a user-defined field assigned by the individual transporting agency.
Pre-H/Transfer	F3.1	Pre-hospital Run Form Available	**RUN_FORM**	Is a Washington Emergency Medical Service Incident Report (WEMSIR) or equivalent pre-hospital record present in the patient's chart at the time of abstracting? 1 = Yes 2 = No
Pre-H/Transfer	F3.1	Run Number	**RUN_NUM**	The run number from the pre-hospital run form.
Pre-H/Transfer	F3.1	Mass Casualty Incident Declared	**MULTI_INC**	Was a Mass Casualty Incident (MCI) declared? Note: Specific working definition of MCI will be determined within each local system. 1 = Yes 2 = No
Pre-H/Transfer	F3.1	Extrication Required	**EXTRIC**	Was extrication required? 1 = Yes 2 = No Note: This includes any type of extrication, not just from vehicles. Do not enter (I)nappropriate in this field.
Pre-H/Transfer	F3.1	Extrication Time Greater Than 20 minutes	**EXTRIC_20**	Was the time required for extrication greater than twenty minutes? 1 = Yes 2 = No Enter (U)nknown if extrication was performed, but the length is not known.

Section	Screen	Data Element Description	Collector Data Name	Definition
Pre-H/Transfer	F3.1	Response Area Type	**AREA**	The Response Area from the pre-hospital run form. 1 = Urban 2 = Suburban 3 = Rural 4 = Wilderness Enter (U)nknown if no Response Area Type is reported
Pre-H/Transfer	F3.1	Prehospital System Activated	**TRAUMA_SYS**	Was the prehospital trauma system activated? 1 = Yes 2 = No I = Inappropriate U = Unknown
Pre-H/Transfer	F3.1	Reason For Destination Decision	**DEST_REASN**	Reason for the Destination Decision? 0 = Did not Transport 1 = Nearest Hospital 2 = Trauma Protocols (nearest designated facility within 30 minutes) 3 = Medical Control direction 4 = Patient or Family request 5 = Patient's Physician's request 6 = Divert from Another Hospital 7 = Other
Pre-H/Transfer	F3.1	Dispatch Date	**PREDATE_D**	The date that the pre-hospital agency was notified of the incident.
Pre-H/Transfer	F3.1	Dispatch Month	**PREDATE_DM**	Indicates the month of dispatch. Valid values range from 01 to 12.
Pre-H/Transfer	F3.1	Dispatch Day	**PREDATE_DD**	Indicates the day of dispatch. Valid values range from 01 to 31.
Pre-H/Transfer	F3.1	Dispatch Year	**PREDATE_DY**	Indicates the year of dispatch. Valid values range from 1980 to 2099.
Pre-H/Transfer	F3.1	Dispatch Time	**PRETIME_D**	Indicates time that the pre-hospital agency was notified of the incident.
Pre-H/Transfer	F3.1	Dispatch Hour	**PRETIME_DH**	Indicates the hour that the pre-hospital agency was notified of the incident. Valid values are from 0 to 23.
Pre-H/Transfer	F3.1	Dispatch Minutes	**PRETIME_DM**	Indicates the minute that the pre-hospital agency was notified of the incident. Valid values are from 0 to 59.
Pre-H/Transfer	F3.1	Scene Arrival	**PRETIME_R**	Indicates the time of arrival of the first EMS agency to reach the patient.
Pre-H/Transfer	F3.1	Arrival Hour of 1st Responder	**PRETIME_RH**	Indicates the hour of arrival of the first EMS agency to reach the patient. Valid values are from 0 and 23.
Pre-H/Transfer	F3.1	Arrival Minutes of 1st Responder	**PRETIME_RM**	Indicates the minute of the time of arrival of the first EMS agency to reach the patient. Valid Values are from 0 and 59.
Pre-H/Transfer	F3.1	Left Scene	**PRETIME_L**	Indicates the time that the patient was taken from the scene by EMS personnel, either en route to a facility or to a rendezvous point with another EMS vehicle. *NOTE: The times reported for 'Arrival of 1st Responder' and 'Patient Left Scene' may be from different agencies*.
Pre-H/Transfer	F3.1	Hour Patient Left Scene	**PRETIME_LH**	Indicates the hour that the patient was taken from the scene by EMS personnel, either en route to a facility or to a rendezvous point with another

Section	Screen	Data Element Description	Collector Data Name	Definition
				EMS vehicle. *NOTE: The times reported for 'Arrival of 1st Responder' and 'Patient Left Scene' may be from different agencies*. Valid values are from 0 and 23.
Pre-H/Transfer	F3.1	Minutes Patient Left Scene	**PRETIME_LM**	Indicates the minute the patient was taken from the scene by EMS personnel, either en route to a facility or to a rendezvous point with another EMS vehicle. *NOTE: The times reported for 'Arrival of 1st Responder' and 'Patient Left Scene' may be from different agencies*. Valid Values are from 0 and 59.
Pre-H/Transfer	F3.1	Scene Time	SCENE_TIME	A Collector calculated data element defined as the elapsed time (in minutes) from arrival at scene to departure from scene. It does not appear on the data entry screen; however it may be selected from the list of elements for use in a data table report or query.
Pre-H/Transfer	F3.1	Incident County Code	**COUNTY**	The county in which the incident occurred. 01 = Adams 02 = Asotin 03 = Benton 04 = Chelan 05 = Clallam 06 = Clark 07 = Columbia 08 = Cowlitz 09 = Douglas 10 = Ferry 11 = Franklin 12 = Garfield 13 = Grant 14 = Grays Harbor 15 = Island 16 = Jefferson 17 = King 18 = Kitsap 19 = Kittitas 20 = Klickitat 21 = Lewis 22 = Lincoln 23 = Mason 24 = Okanogan 25 = Pacific 26 = Pend Oreille 27 = Pierce 28 = San Juan 29 = Skagit 30 = Skamania 31 = Snohomish 32 = Spokane 33 = Stevens 34 = Thurston 35 = Wahkiakum 36 = Walla Walla 37 = Whatcom 38 = Whitman 39 = Yakima 45 = Oregon 50 = Idaho 60 = Alaska 70 = Canada 80 = Other States 90 = Other Countries

Section	Screen	Data Element Description	Collector Data Name	Definition
Pre-H/Transfer	F3.2	Nailbed	**NAILBED**	The time for capillary refill, as measured by "nail pinch". 1 = Two Seconds or Less 2 = More than Two Seconds 3 = No Response
Pre-H/Transfer	F3.2	Pupils	**PUPILS**	Pupil size 1 = Equal 2 = Not Equal
Pre-H/Transfer	F3.2	GCS: Eye Opening	**EYE_OPNG_S**	Sub-score of the Glasgow Coma Score (GCS) indicating patient ***best*** eye opening ***at the scene***. It is added to two other sub-scores to obtain the GCS at the scene. See GCS at scene (GCS_S). 1 = None 2 = To Pain 3 = To Voice 4 = Spontaneous U = Unknown
Pre-H/Transfer	F3.2	Verbal Response	**VER_RESP_S**	Sub-score of the Glasgow Coma Score (GCS) indicating patient *best* verbal response ***at the scene***. It is added to two other sub-scores to obtain the GCS at the scene. See also GCS at scene (GCS_S). 1 = None, intubated, or pharmacologically paralyzed 2 = Incomprehensible Sounds (under 2 yrs, Agitated/Restless) 3 = Inappropriate Words (under 2 yrs., Persistent Crying) 4 = Confused 5 = Oriented U = Unknown
Pre-H/Transfer	F3.2	Motor Response	**MOT_RESP_S**	Sub-score of the Glasgow Coma Score (GCS) indicating the patient's *best* motor response ***at the scene***. It is added to two other sub-scores to obtain the GCS at the scene. See GCS at scene (GCS_S). 1 = None, or pharmacologically paralyzed 2 = Abnormal Extension 3 = Abnormal Flexion 4 = Withdraws to Pain 5 = Localizes Pain 6 = Obeys Commands U = Unknown
Pre-H/Transfer	F3.2	GCS Total	**GCS_S**	Glasgow Coma Score at the Scene (GCS) is a widely used index that assesses the degree of coma in patients with craniocerebral injuries. The *pre-hospital* GCS is calculated by adding the sub-scores of three behavioral responses at the scene: *best* eye opening (see EYE_OPNG_S), best verbal response (see VER_RESP_S), and best motor response (see MOT_RESP_S). If any of the sub-scores are unavailable but the total GCS is known, the abstractor may enter it here. If not, enter "U" for unknown. Values range from 3 to 15.
Pre-H/Transfer	F3.2	Was Patient Intubated at the time of GCS	**INTUBAT_S**	Indicates whether the patient was intubated at the time of Glasgow Coma Score evaluation at the scene. If there is no indication that the GCS score was evaluated, enter Unknown. Inappropriate is not a valid value for this data element. 1 = Yes 2 = No

Section	Screen	Data Element Description	Collector Data Name	Definition
Pre-H/Transfer	F3.2	Was the Patient pharmacologic-ally paralyzed at the time of CGS	**PARALYZ_S**	Indicates whether the patient pharmacologically paralyzed at the time of Glasgow Coma Score evaluation at the scene. If there is not indication that the GCS score was evaluated, enter Unknown. Inappropriate is not a valid value for this data element. 1 = Yes 2 = No
Pre-H/Transfer	F3.2	Vital Signs: Time	**VIT_TIM**	The time that the first vital signs were taken by pre-hospital personnel. See the definitions of each individual vital sign (SYS_BP_S, RESP_RAT_S, PULSE_S) for a complete description of which measurements should be recorded for the pre-hospital vital signs.
Pre-H/Transfer	F3.2	Vital Signs Hour	**VIT_TIM_H**	The hour that the systolic blood pressure was taken by pre-hospital personnel. Valid values are from 00 to 23.
Pre-H/Transfer	F3.2	Vital Signs Minutes	**VIT_TIM_M**	The minutes the systolic blood pressure was taken by pre-hospital personnel. Valid values are 00 to 59.
Pre-H/Transfer	F3.2	Vitals From First Agency	**FIRST_VIT**	Did the vitals come from the First Licensed Agency on Scene? 1 = Yes 2 = No U = Unknown
Pre-H/Transfer	F3.2	Posture	**POSTURE**	Patient's position during pre-hospital vital signs assessment. If position is not specified in the incident report, please enter unknown. 1 = Lying 2 = Sitting 3 = Upright U = Unknown
Pre-H/Transfer	F3.2	Pulse Rate	**PULSE_S**	Pulse rate at scene in beats per minute. If several pulse rates are taken, enter the one nearest in time to the Systolic Blood Pressure.
Pre-H/Transfer	F3.2	Respiratory Rate	**RESP_RAT_S**	The number of *unassisted* respirations by the patient per minute (Do NOT use the bagged or controlled ventilator rate). If several respiratory rates were taken, enter the rate nearest in time to the lowest SBP recorded. Enter (U)nknown If the patient's ***unassisted*** respiratory rate could not be recorded. .
Pre-H/Transfer	F3.2	Systolic Blood Pressure	**SYS_BP_S**	Systolic blood pressure during prehospital care (at the scene or during transport), in mm of Hg. Use the ***lowest*** systolic blood pressure when several blood pressures are taken.
Pre-H/Transfer	F3.2	Pre-Hospital Index (PHI) Respirations	**PHI_RESP**	The 'respirations' component of the Pre-hospital Index (PHI) field triage score. Use the ***worst*** value if several are available. 1 = Normal 2 = Labored or Shallow 3 = <10/Minute (or needs intubation)[1] U = unknown
Pre-H/Transfer	F3.2	Pre-Hospital Index (PHI) Consciousness	**PHI_CONSC**	The 'consciousness' component of the Pre-hospital Index (PHI) field triage score. Use the ***worst*** value if several are available (except, do not include a brief, initial loss of consciousness as the worst value).

Section	Screen	Data Element Description	Collector Data Name	Definition
				1 = Normal 2 = Confused or Combative 3 = No Intelligible Words U = unknown
Pre-H/Transfer	F3.2	Pre-Hospital Index (PHI) Penetrating Wound (Chest, Abdomen)	**PHI_PENT**	The 'Penetrating' component of the Pre-hospital Index (PHI) field. Indicates whether the injury was from a penetrating wound to the chest or abdomen. 1 = Yes 2 = No U = Unknown
Pre-H/Transfer	F3.2	Pre-Hospital Index (PHI)	**PHI**	Note: This field is calculated by Collector. Enter a PHI Total only if this field is still blank when the rest of Screen 3.2 has been completed (that is, one or more of the PHI components are missing), and if the PHI total is included in the Emergency Department record. A field triage score used in determining triage protocols. The components of the PHI are 1) systolic blood pressure, 2) pulse, 3) respirations, 4) consciousness and 5) penetrating vs. not penetrating wound. Collector will compute the total if all the component information is available. However, if all the data needed to compute this score is not available but the total PHI is known, the abstractor can enter it here. See also the individual PHI components for their definitions and defined values. Each of the components are assigned a score based on their values as follows: **Systolic blood pressure (SBP)** > 100 **has a score of** 0 86-100 1 75-85 2 0-74 5 **Pulse rate** > 120 3 50-120 0 <50 5 **Respirations** 1 has a score of 0 2 has a score of 3 3 has a score of 5 **Consciousness** 1 has a score of 0 2 has a score of 3 3 has a score of 5 **Penetrating Wound?** 1(yes) has a score of 4 Otherwise score of 0 PHI = SBP_{score} + $Pulse_{score}$ + $Respirations_{score}$ + $Consciousness_{score}$ + Penetrating $Wound_{score}$[1] 1. Journal of Trauma, 1997, Vol.43, No. 2, p.284
Pre-H/Transfer	F3.2	Field Interventions	**INTERV_S1**	Field Intervention # 1 of 8 maximum allowed. 00 = None 01 = O2 (Oxygen) 02 = Wound Care 03 = Extrication/Rescue 04 = Splinting 05 = Cervical Collar, Backboard 07 = ECG Monitor 08 = Oral Airway/Bag Mask

Section	Screen	Data Element Description	Collector Data Name	Definition
				10 = CPR 11 = Shock Trouser 12 = Automatic DC Shock 13 = Manual DC Shock 14 = Endotracheal Intubation 17 = IV, Central Line 18 = IV, Peripheral 19 = IV, Intraosseous 20 = Needle Thoracostomy 21 = Pericardiocentesis 22 = Cricothyrotomy 23 = Other 24 = Multilumen Airway 25 = Baseline Blood 26 = Blood Transfusion **Drug Therapy** 51 = Diphenhydramine 52 = Anticholinergic - Antimuscarinic/Antispasmodic 53 = Sympathomimetic (Adrenergic) 54 = Skeletal Muscle Relaxants: Succinylcholine 55 = Coagulants and Anticoagulants: Heparin 56 = Cardiac Drugs 57 = Vasodilating Agents 58 = Nonsteroidal: Aspirin 59 = Opiate Agonists: Meperidine, Morphine 60 = Opiate Antagonists: Naloxone 61 = Misc: Acetaminophen 62 = Benzodiazepines: Diazepam 63 = Misc: Magnesium Sulfate 64 = Benzodiazepines: Lorazepam 65 = Alkalinizing Agents: Sodium Bicarbonate 66 = Replacement: Calcium (Chloride/Gluconate) 67 = Caloric Agents: Dextrose & Water 68 = Diuretics 69 = Antacids & Adsorbents: Activated Charcoal 70 = Emetics: Ipecac 71 = Misc GI: Metoclopramide 72 = Adrenals: Dexamethasone,Methylprednisolone 73 = Antidiabetic - Misc: Glucagon 74 = Other Medications
Pre-H/Transfer	F3.2	Field Intervention 2	**INTERV_S2**	Field Intervention # 2 of 8 maximum allowed. See field intervention 1 (INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Field Intervention 3	**INTERV_S3**	Field Intervention # 3 of 8 maximum allowed. See field intervention 1 (INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Field Intervention 4	**INTERV_S4**	Field Intervention # 4 of 8 maximum allowed. See field intervention 1 (INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Field Intervention 5	**INTERV_S5**	Field Intervention # 5 of 8 maximum allowed. See field intervention 1 (INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Field Intervention 6	**INTERV_S6**	Field Intervention # 6 of 8 maximum allowed. See field intervention 1 (INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Field Intervention 7	**INTERV_S7**	Field Intervention # 7 of 8 maximum allowed. See field intervention 1 (INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Field	**INTERV_S8**	Field Intervention # 8 of 8 maximum allowed. See field intervention 1

Section	Screen	Data Element Description	Collector Data Name	Definition
		Intervention 8		(INTERV_S1) for defined values.
Pre-H/Transfer	F3.2	Triage Criteria Used:	**TRIAG_S_1**	1st of three most important criteria used to identify this patient as a major trauma victim as recorded on the pre-hospital run form. **Vital Signs and Level of Consciousness**: 01 = Systolic Blood Pressure < 90 (PEDS: BP < 90 or capillary refill > 2 seconds) 02 = Heart Rate > 120 (PEDS: HR < 60 or > 120) 03 = Respiratory Rate <10 or >29 04 = Altered Mental Status **Assess Anatomy of Injury** 05 = Penetrating Injury of Head, Neck, Torso, Groin 06 = Combination of Burns ≥ 20% or Involving Face/Airway 07 = Amputation Above Wrist or Ankle 08 = Spinal Cord Injury 09 = Flail Chest 10 = Two or More Obvious Proximal Long Bone Fractures **Biomechanics of Injury** 11 = Death of Same Car Occupant 12 = Ejection of Patient from Enclosed Vehicle 13 = Falls ≥ 20 Feet 14 = Pedestrian Hit at ≥ 20 MPH or Thrown ≥ 15 Feet **High Energy Transfer Situation** 15 = Rollover 16 = Motorcycle, ATV, Bicycle Accident 17 = Extrication Time > 20 Minutes 18 = Significant Intrusion **Other Risk Factors** 19 = Extremes of Age (<15 or >60) 20 = Hostile Environment (Extremes of Heat or Cold) 21 = Medical Illness (such as COPD, CHF, Renal Failure, etc.) 22 = Second or Third Trimester Pregnancy 23 = **Gut Feeling of Medic**
Pre-H/Transfer	F3.2	Triage Criteria 2	**TRIAG_S_2**	2nd of three most important criteria used to identify this patient as a major trauma victim *as recorded on the pre-hospital run form.* See TRIAG_S_1 for values.
Pre-H/Transfer	F3.2	Triage Criteria 3	**TRIAG_S_3**	3rd of three most important criteria used to identify this patient as a major trauma victim *as recorded on the pre-hospital run form.* See TRIAG_S_1 for values.
Pre-H/Transfer	F3.2	Pediatric Trauma Score (PTS)	**PTS_S**	The Pediatric (age 0-14) Trauma Score at the scene of the accident. See PTS_A for a complete definition.
Pre-H/Transfer	F3.2	Revised Trauma Score (RTS)	**RTS_S**	The Revised Trauma Score (RTS) is a physiologic severity score widely used in pre-hospital triage and based on measurements of vital signs [systolic blood pressure (SBP), respiratory rate (RR) and a measurement of consciousness [(Glasgow Coma Scale (GCS)]. The RTS provides a more accurate estimation of injury severity for patients with serious head injuries, and supplies more reliable predictions of outcome than its predecessor -- the Trauma Score. The RTS at the scene (RTS_{scene}) is computed by adding the coded values of GCS, SBP, and RR at the scene as follows:

Section	Screen	Data Element Description	Collector Data Name	Definition
				$RTS_{scene} = GCS_{coded\ value} + SBP_{coded\ value} + RR_{coded\ value}$ **GCS_{scene} / SBP_{scene} / RR_{scene} / Coded Value** 13 – 15 / >89 / 10 - 29 / 4 9 – 12 / 76 - 89 / >29 / 3 6 - 8 / 50 - 75 / 6 - 9 / 2 4 - 5 / 1 - 49 / 1 - 5 / 1 3 / 0 / 0 / 0 NOTE: The RTS at the scene does not use weighted values as does the RTS in the ED since it is easier to sum the coded values at the scene. RTS values at the scene range from 12 (best) to 0 (worst). See also GCS_S, SYS_BP_S, and RESP_RAT_S.
Pre-H/Transfer	F3.3	Transferred in	**REF_HOSP**	Indicates whether the patient was transferred in from another hospital (known as the referring hospital). A 'referral' is a patient sent to your hospital from another licensed acute care facility or a 'Designated Level V Trauma Service'. A patient sent to your hospital from a private doctor's office, clinic, nursing home, ambulatory surgery center, etc. that is *not* designated as a Level V service is considered a transport directly from the field -- *not* a referral. 1 = Yes 2 = No Do not use Inappropriate or Unknown (removed from menu). Note: A patient is "transferred" from another hospital if sent by ambulance. A patient sent by private vehicle or other means is not a "transfer" for the purposes of the Trauma Registry.
Pre-H/Transfer	F3.3	Transport Mode	**TRANSP_R**	Indicates how the patient was transported from the referring facility, if applicable. *Note that "transport" refers to the unit that provides most of the transportation between the scene and the receiving facility.* 1 = Ground Ambulance (Pre-Hospital Agency) 2 = Helicopter (Pre-Hospital Agency) 3 = Fixed Wing Aircraft (Pre-Hospital Agency) 4 = Police (or other Law Enforcement, not a Pre-Hospital agency) 5 = Private Vehicle (not a Pre-Hospital agency) 6 = Other
Pre-H/Transfer	F3.3	Level of Personnel	**LEV_R**	The *level of service* from the agency which transports from the referring facility, if applicable. 1 = ALS (Paramedic, RN, MD) 2 = ILS (IV Tech, Airway Tech, IV/Airway Tech) 3 = BLS (Advanced First Aid, First Responder, EMT)
Pre-H/Transfer	F3.3	Transporting Agency ID Number	**RTRANSP_AG**	**Agency (license) Number** of Primary Transporting Agency that transported the patient from the referring hospital to another hospital, if applicable. 'Primary Transport' refers to the unit that provides *mos*t of the medical care between the sending facility and the receiving facility. *Example: A helicopter transports a patient from a rural hospital to a landing site a few blocks from an urban trauma center. The patient is transported the last few blocks by ground ambulance. The air ambulance (helicopter) is the primary transportation.*
Pre-H/Transfer	F3.3	Unit Number	**RTRANSP_UN**	The ID # of the ***unit*** that transported the patient from the referring hospital to another hospital, if applicable. This is a user-defined field assigned by the individual transporting agency.
Pre-H/Transfer	F3.3	Run Form	**RRUN_FORM**	Is a Washington Emergency Medical Service Incident Report (WEMSIR) or

Section	Screen	Data Element Description	Collector Data Name	Definition
		Available		equivalent pre-hospital record of the inter-hospital ***transfer*** present in the patient's chart at the time of abstracting? 1 = Yes 2 = No
Pre-H/Transfer	F3.3	Run Number	**RRUN_NUM**	Indicates the inter-hospital transport run number from the Washington Emergency Medical Service Incident Report (WMSIR) or other pre-hospital form.
Pre-H/Transfer	F3.3	Dispatch Date	**REFDATE_D**	The date that the Agency performing the Interfacility Transport was dispatched.
Pre-H/Transfer	F3.3	Dispatch Month	**REFDATE_DM**	Indicates the month of dispatch. Valid values range from 01 to 12.
Pre-H/Transfer	F3.3	Dispatch Day	**REFDATE_DD**	Indicates the day of dispatch. Valid values range from 01 to 31.
Pre-H/Transfer	F3.3	Dispatch Year	**REFDATE_DY**	Indicates the year of dispatch. Valid values range from 1980 to 2099.
Pre-H/Transfer	F3.3	Dispatch Time	**REFTIME_D**	The time that the Agency performing the Interfacility Transport was notified of the transport.
Pre-H/Transfer	F3.3	Dispatch Hour	**REFTIME_DH**	Indicates the hour of dispatch. Valid values are from 0 to 23.
Pre-H/Transfer	F3.3	Dispatch Minutes	**REFTIME_DM**	Indicates the minutes of dispatch. Valid values are 0 to 59.
Pre-H/Transfer	F3.3	Arrival	**REFTIME_R**	Indicates the time that the unit performing the Interfacility Transport arrives at the referring facility.
Pre-H/Transfer	F3.3	Arrival Hour	**REFTIME_RH**	Indicates the hour of arrival at the referring facility. Valid values are from 0 to 23.
Pre-H/Transfer	F3.3	Arrival Minutes	**REFTIME_RM**	Indicates the minutes of arrival at the referring facility. Valid values are from 01 to 59.
Pre-H/Transfer	F3.3	Left Ref. Hosp. Time	**REFTIME_L**	Indicates the time that the unit performing the Interfacility Transport leaves the referring facility.
Pre-H/Transfer	F3.3	Left Ref. Hosp. Hour	**REFTIME_LH**	Indicates the hour of departure from the referring facility. Valid values are from 0 to 23.
Pre-H/Transfer	F3.3	Left Ref. Hosp. Minutes	**REFTIME_LM**	Indicates the minutes of departure from the referring facility. Valid values are from 0 to 59.
Pre-H/Transfer	F3.3	Transport From	**REF_ID**	ID # of the referring hospital if REF_ID = yes. A menu will appear with Washington Hospitals listed in alphabetical order. Selecting Oregon, Idaho, Montana, Alaska, or British Columbia will display *user-defined* menus of hospitals in those states, if defined. 146 = Allenmore Hospital (Tacoma) 183 = Auburn Regional Medical Center (Auburn) 197 = Capital Medical Center (Olympia) 158 = Cascade Medical Center (Leavenworth) 106 = Cascade Valley Hospital (Arlington) 168 = Central Washington Hospital (Wenatchee) 014 = Children's Hospital Regional Medical Center (Seattle) 045 = Columbia Basin Hospital (Ephrata) 150 = Coulee Community Hospital (Grand Coulee) 965 = Darrington Clinic (Darrington) 141 = Dayton General Hospital (Dayton) 037 = Deaconess Medical Center (Spokane)

Section	Screen	Data Element Description	Collector Data Name	Definition
				042 = Deer Park Hospital (Spokane) 111 = East Adams Rural Hospital (Ritzville) 507 = Eastern State Hospital (Spokane) 035 = Enumclaw Community Hospital (Enumclaw) 164 = Evergreen Hospital Medical Center (Kirkland) 707 = Fairchild Air Force Base Hospital (Fairchild AFB) 167 = Ferry County Memorial Hospital (Republic) 148 = Fifth Avenue Medical Center (Seattle) 054 = Forks Community Hospital (Forks) 082 = Garfield County Hospital District (Pomeroy) 081 = Good Samaritan Community Hospital (Puyallup) 063 = Grays Harbor Community Hospital (Aberdeen) 020 = Group Health Central Hospital (Seattle) 169 = Group Health Eastside Hospital (Redmond) 029 = Harborview Medical Center (Seattle) 142 = Harrison Memorial Hospital (Bremerton) 126 = Highline Community Hospital (Burien) 139 = Holy Family Hospital (Spokane) 200 = Hospice Care Center Hospital (Longview) 961 = Inter-Island Medical Center (Friday Harbor) 163 = Island Hospital (Anacortes) 085 = Jefferson General Hospital (Port Townsend) 161 = Kadlec Medical Center (Richland) 039 = Kennewick General Hospital (Kennewick) 966 = Kittitas County Hospital District #2 (Cle Elum) 140 = Kittitas Valley Community Hospital (Ellensburg) 008 = Klickitat Valley Hospital (Goldendale) 165 = Lake Chelan Community Hospital (Chelan) 137 = Lincoln Hospital (Davenport) 022 = Lourdes Medical Center (Pasco) 720 = Madigan Army Medical Center (Tacoma) 186 = Mark Reed Hospital (McCleary) 175 = Mary Bridge Children's Hospital (Tacoma) 152 = Mason General Hospital (Shelton) 147 = Mid-Valley Hospital (Omak) 173 = Morton General Hospital (Morton) 030 = Mount Carmel Hospital (Colville) 701 = Naval Air Station (US) (Whidbey Island) 704 = Naval Regional Med. Center (Bremerton) 021 = Newport Community Hospital (Newport) 107 = North Valley Hospital (Tonasket) 130 = Northwest Hospital (Seattle) 079 = Ocean Beach Hospital (Ilwaco) 080 = Odessa Memorial Hospital (Odessa) 023 = Okanogan-Douglas County Hospital (Brewster) 038 = Olympic Medical Center (Port Angeles) 125 = Othello Community Hospital (Othello) 131 = Overlake Hospital Medical Center (Bellevue) 046 = Prosser Memorial Hospital (Prosser) 191 = Providence Centralia Hospital (Centralia) 027 = Providence Everett Medical Center (Everett) 159 = Providence St. Peter Hospital (Olympia) 003 = Providence Medical Center (Seattle) 083 = Puget Sound Hospital (Tacoma) 172 = Pullman Memorial Hospital (Pullman) 129 = Quincy Valley Medical Center (Quincy) 162 = Sacred Heart Medical Center (Spokane) 078 = Samaritan Hospital (Moses Lake) 043 = Shriners Hospital for Children (Spokane) 073 = Skagit Valley Hospital(Mt. Vernon) 096 = Skyline Hospital (Whitesalmon)

Section	Screen	Data Element Description	Collector Data Name	Definition
				170 = Southwest Washington Medical Center (Vancouver) 132 = St. Clare Hospital (Tacoma) 201 = St. Francis Community Hospital (Federal Way) 026 = St. John's Medical Center (Longview) 145 = St. Joseph Hospital Main Campus (E. Chestnut, Bellingham) 145 = St. Joseph Hospital (Squalicum Pkwy, Bellingham) 194 = St. Joseph Hospital of Chewelah (Chewelah) 032 = St. Joseph Medical Center (Tacoma) 050 = St. Mary Medical Center (Walla Walla) 138 = Stevens Hospital (Edmonds) 198 = Sunnyside Community Hospital (Sunnyside) 001 = Swedish Medical Center -- Ballard (Seattle) 001 = Swedish Medical Center -- Seattle (Seattle) 176 = Tacoma General Hospital (Tacoma) 199 = Toppenish Community Hospital (Toppenish) 108 = Tri-State Memorial Hospital (Clarkston) 967 = United General Hospital (Sedro Woolley) 128 = University of Washington Medical Center (Seattle) 104 = Valley General Hospital (Monroe) 180 = Valley Hospital & Medical Center (Spokane) 155 = Valley Medical Center (Renton) 710 = Veterans Administration Hospital (Seattle) 705 = Veterans Administration Hospital -- American (Tacoma) 715 = Veterans Administration Hospital (Spokane) 010 = Virginia Mason Hospital (Seattle) 044 = Walla Walla General Hospital (Walla Walla) 506 = Western State Hospital (Tacoma) 156 = Whidbey General Hospital (Coupeville) 153 = Whitman Hospital & Medical Center (Colfax) 056 = Willapa Harbor Hospital (South Bend) 102 = Yakima Regional Medical Center (Yakima) 058 = Yakima Valley Memorial Hospital (Yakima) **California** 084 = General Hospital Medical Center (Eureka) **Oregon** 916 = Emanuel Hospital (Portland) 915 = Good Shepherd Hospital (Hermiston) 911 = Grande Ronde Hospital (La Grande) 917 = OHSU Hospital (Portland) 914 = Pioneer Memorial Hospital (Prinville) 912 = St. Anthony Hospital (Pendleton) 700 = Veterans Administration Hospital -- Vancouver (Portland) 913 = Wallowa Memorial Hospital (Enterprise) 910 = Other Oregon Hospitals **Idaho** 950 = St. Joseph Regional Medical (Lewiston) 952 = Gritman Medical Center (Moscow) 940 = Idaho Hospitals (NOS) **Montana** 945 = Other Montana Hospitals **Alaska** 930 = Other Alaska Hospitals **British Columbia** 920 = Other British Columbia Hospitals

Section	Screen	Data Element Description	Collector Data Name	Definition
				960 = All Other Hospitals 970 = Doctor's Office, Nursing Home or Other Care Facility 997 = Field (Scene, Residence) 998 = Rendezvous Note: If "960 = All Other Hospital" is chosen, enter name of referring hospital below. Note: Do not use 970, 997, or 998 in this field. A transfer is from a licensed hospital (or designated Level V Trauma Service). A patient transported from a doctor's office or rendezvous is not considered a transfer
Pre-H/Transfer	F3.3	If Other	**REF_OTHER**	Name of the referring hospital if "960 = All Other Hospital' was chosen for the referring hospital ID (see REF_ID).
Pre-H/Transfer	F3.3	Reason for Referral	REF_REASON	This is a user-defined menu.
Pre-H/Transfer	F3.3	Arrive Referring Hospital	REF_AR_D	Date of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital.
Pre-H/Transfer	F3.3	Month of Arrival at Referring Hospital	REF_AR_D_M	Month of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 1 to 12.
Pre-H/Transfer	F3.3	Day of Arrival at Referring Hospital	REF_AR_D_D	Day of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 1 to 31.
Pre-H/Transfer	F3.3	Year of Arrival at Referring Hospital	REF_AR_D_Y	Year of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 1980 to 2099.
Pre-H/Transfer	F3.3	Time of Arrival at Referring Hospital	REF_AR_T	Time of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital.
Pre-H/Transfer	F3.3	Hour of Arrival at Referring Hospital	REF_AR_T_H	Hour of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 0 to 23.
Pre-H/Transfer	F3.3	Minutes of Arrival at Referring Hospital	REF_AR_T_M	Minute of arrival at the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 0 to 59.
Pre-H/Transfer	F3.3	Depart Referring Hospital	REF_DP_D	Date of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital.
Pre-H/Transfer	F3.3	Month of Departure from Referring Hospital	REF_DP_D_M	Month of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 1 to 12.
Pre-H/Transfer	F3.3	Day of Departure from Referring Hospital	REF_DP_D_D	Day of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 1 to 31.
Pre-H/Transfer	F3.3	Year of Departure from Referring Hospital	REF_DP_D_Y	Year of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 1980 to 2099.
Pre-H/Transfer	F3.3	Time of Departure from Referring Hospital	REF_DP_T	Time of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital.
Pre-H/Transfer	F3.3	Hour of Departure from	REF_DP_T_H	Hour of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 0 to 23.

Section	Screen	Data Element Description	Collector Data Name	Definition
		Referring Hospital		
Pre-H/Transfer	F3.3	Minutes of Departure from Referring Hospital	REF_DP_T_M	Minute of departure from the hospital that refers the patient (i.e. the 'referring hospital') to another hospital. Valid values range from 0 to 59.
Pre-H/Transfer	F3.3	Referring Facility Interventions	RPROC_01	1st of 10 possible Referring Facility Interventions. Select from the Primary Procedure List first, then select from the Secondary Procedure List. **PRIMARY PROCEDURE LIST** 00 = None 03 = Angiography, Arteriogram, or Aortagram 01 = Airway, Endotracheal Intubation 211 = Benzodiazepines (valium, ativan, versed, etc.) 09 = Blood Product Transfusion 10 = CPR 49 = CT Abdomen 50 = CT Cervical Spine 51 = CT Chest 13 = CT Head 33 = Diagnostic Peritoneal Lavage (DPL) 217 = Diuretics (lasix, mannitol, etc.) 57 = Echocardiogram 21 = Fluid Resuscitation 203 = Neuromuscular Blocking Agents (succinylcholine, vecuronium, etc.) 208 = Opiates (meperidine, morphine, etc.) 221 = Steroids (dexamethasone, methylprednisolone, etc.) 40 = Thoracostomy, Chest Tube 30 = Thoracotomy (Open Chest) 42 = Tracheostomy or Cricothyroidotomy 69 = Ultrasound 43 = Warming Methods **SECONDARY PROCEDURE LIST** 210 = Acetaminophen 224 = Antibiotics 04 = Arterial Blood Gases 05 = Arterial Line 06 = Autotransfusion 02 = Bag/Valve/Mask Ventilation 07 = Baseline Blood 209 = Benzodiazepine Antagonist or Opiate Antagonist 47 = Bronchoscopy 48 = Capnography or End Tidal CO2 205 = Cardiovascular Drugs (epinephrine, lidocaine, etc.) 11 = Cervical Collar/Backboard 12 = Closed Reduction(s) 52 = CT Facial 53 = CT Lumbar-Sacral Spine 54 = CT Pelvis 55 = CT Thoracic Spine 56 = CT Other 15 = Cutdown 16 = Cystogram 17 = Defibrillation 18 = Doppler Study 19 = ECG Monitor 20 = Fetal Heart Rate Monitor 58 = Fetal Heart Tone Auscultation 22 = Foley Catheter 220 = GI Drugs (droperidol, metoclopramide, etc.)

Section	Screen	Data Element Description	Collector Data Name	Definition
				59 = HCG, Urine or Serum 60 = Hyperventilation 225 = Immunizations, Vaccinations 23 = Intracranial Pressure Monitor 24 = IV, Central Line 25 = IV, Intraosseous 226 = IV, Isotonic Crystalloids (NS, LR, etc.) 26 = IV, Peripheral 27 = K-wire or Steinman Pin Insertion 61 = MRI Abdomen 62 = MRI Brain 28 = MRI Cervical Spine 63 = MRI Chest 64 = MRI Lumbar or Sacral Spine 65 = MRI Other 66 = MRI Pelvis 67 = MRI Thoracic Spine 29 = Naso- or Oro-gastric Tube 207 = Nonsteroidal Anti-inflammatory Drugs (aspirin, ibuprofen, ketorolac, etc.) 46 = Other 31 = Oxygen 32 = Pericardiocentesis 68 = Pulse Oximetry 08 = Repeat H&H 34 = Shock Trouser 35 = Skeletal Traction 36 = Splinting 37 = Suture or Staple Laceration 38 = Temperature Monitor 39 = Thoracostomy, Needle 41 = Tongs or Halo 44 = Wound Care 45 = X-ray 100 – 199 = User-defined Interventions/Procedures
Pre-H/Transfer	F3.3	Referring Facility Interventions 2	RPROC_02	2nd of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 3	RPROC_03	3rd of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 4	RPROC_04	4th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 5	RPROC_05	5th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 6	RPROC_06	6th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 7	RPROC_07	7th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 8	RPROC_08	8th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.3	Referring Facility Interventions 9	RPROC_09	9th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.

Section	Screen	Data Element Description	Collector Data Name	Definition
Pre-H/Transfer	F3.3	Referring Facility Interventions 10	RPROC_10	10th of 10 possible Referring Facility Interventions. See 1st referring facility intervention for possible values.
Pre-H/Transfer	F3.4	Pre-Hospital Memo	NOTES_PRE	Ten lines designated for a description of pre-hospital information.
ED Data	F4.1	Emergency Department Arrival (EDA) Date	**EDA_DATE**	Emergency Department Arrival (EDA) Date. NOTE: If the patient was a direct admit, the admit date should be entered here. It will automatically be entered as the ED Discharge Date by the program.
ED Data	F4.1	Emergency Department Arrival (EDA) Month	**EDA_DATE_M**	Month of Emergency Department Arrival (EDA). NOTE*:* ***If the patient was a direct admit, a skip will jump from RESPONSE LEVEL (screen 4.1) to PREEXISTING CONDITIONS (screen 4.2).*** Valid values are from 1 to 12.
ED Data	F4.1	Emergency Department Arrival (EDA) Day	**EDA_DATE_D**	Day of Emergency Department Arrival (EDA). NOTE*:* ***If the patient was a direct admit, a skip will jump from RESPONSE LEVEL (screen 4.1) to PREEXISTING CONDITIONS (screen 4.2).*** Valid values are from 1 to 31.
ED Data	F4.1	Emergency Department Arrival (EDA) Year	**EDA_DATE_Y**	Year of Emergency Department Arrival (EDA). NOTE*:* ***If the patient was a direct admit, a skip will jump from RESPONSE LEVEL (screen 4.1) to PREEXISTING CONDITIONS (screen 4.2).*** Valid values are from 1980 to 2099.
ED Data	F4.1	Emergency Department Arrival (EDA) Time	**EDA_TIME**	Emergency Department Arrival (EDA) Time. NOTE: If the patient was a direct admit, the admit time should be entered here. It will automatically be entered as the ED Discharge Time by the program.
ED Data	F4.1	Emergency Department Arrival (EDA) Hour	**EDA_TIME_H**	Emergency Department Arrival (EDA) Hour. NOTE*:* ***If the patient was a direct admit, a skip will jump from RESPONSE LEVEL (screen 4.1) to PREEXISTING CONDITIONS (screen 4.2).*** Valid values are from 0 to 23.
ED Data	F4.1	Emergency Department Arrival (EDA) Minutes	**EDA_TIME_M**	Emergency Department Arrival (EDA) Minutes. NOTE*:* ***If the patient was a direct admit, a skip will jump from RESPONSE LEVEL (screen 4.1) to PREEXISTING CONDITIONS (screen 4.2).*** Valid values are from 0 to 59.
ED Data	F4.1	Direct Admit	**DIRECT_ADM**	Identifies a patient that was admitted without going through the Emergency Department. Unknown or Inappropriate are not valid responses for this data element. 1 = Yes 2 = No Note: When a patient is indicated as a Direct Admit: a. The Admit date and time should be entered into the ED Admit date and time fields b. The ED Discharge date and time will default to the admit date and time thereby making the ED length of stay zero c. A skip will only allow the following ED elements to be entered: • DOA • Trauma Team Activated • Response Level • Preexisting Conditions • GCS • PTS • Intubated

Section	Screen	Data Element Description	Collector Data Name	Definition
				• Paralyzed • Vital Signs
ED Data	F4.1	Dead on Arrival (DOA)	**DOA**	Indication on medical record that this patient was dead on arrival at your facility (i.e. no resuscitative efforts started or continued by the facility). 1 = Yes 2 = No Note: Do not use (I)nappropriate or (U)nknown in this field.
ED Data	F4.1	Trauma Team Activated?	**TRAUMA_ACT**	Indicates whether the facility activated its Trauma Resuscitation Team. The Trauma Resuscitation Team provides initial evaluation and treatment of the trauma patient. As defined in WAC and for the purposes of WTR, the Trauma Team is a group organized and directed by a general surgeon who assumes responsibility for coordination of overall care of the trauma patient. The Team includes an emergency physician who is responsible for: 1) activating the trauma team using an approved scoring system; 2) arrival of the surgeon in the resuscitation area. Other team members, as well as operational details, are described in the hospital's approved application for designation. 1 = Yes (Full or Modified Trauma Team Activation) 2 = No (This may includes a call for a trauma consult, but without full or modified activation of the trauma team).
ED Data	F4.1	Trauma Response Level	**RESUS**	1 = Full Trauma Response. Indicates activation of the Trauma Resuscitation Team, including the Surgeon. See also TRAUMA_ACT. 2 = Modified Trauma Response (as defined by the facility) 3 = Trauma Consult (seen by general surgeon in ED on a non-emergent basis) 4 = None
ED Data	F4.1	ED Procedure 1	**ED_PROC_01**	In ED Procedures 1-10, enter the procedures that are ***most important*** to the resuscitation of this patient. **PRIMARY PROCEDURE LIST** 00 = None 03 = Angiography, Arteriogram, or Aortagram 01 = Airway, Endotracheal Intubation 211 = Benzodiazepines (valium, ativan, versed, etc.) 09 = Blood Product Transfusion 10 = CPR 49 = CT Abdomen 50 = CT Cervical Spine 51 = CT Chest 13 = CT Head 33 = Diagnostic Peritoneal Lavage (DPL) 217 = Diuretics (lasix, mannitol, etc.) 57 = Echocardiogram 21 = Fluid Resuscitation 203 = Neuromuscular Blocking Agents (succinylcholine, vecuronium, etc.) 208 = Opiates (meperidine, morphine, etc.) 221 = Steroids (dexamethasone, methylprednisolone, etc.) 40 = Thoracostomy, Chest Tube 30 = Thoracotomy (Open Chest) 42 = Tracheostomy or Cricothyroidotomy 69 = Ultrasound 43 = Warming Methods **SECONDARY PROCEDURE LIST** 210 = Acetaminophen 224 = Antibiotics

Section	Screen	Data Element Description	Collector Data Name	Definition
				04 = Arterial Blood Gases 05 = Arterial Line 06 = Autotransfusion 02 = Bag/Valve/Mask Ventilation 07 = Baseline Blood 209 = Benzodiazepine Antagonist or Opiate Antagonist 47 = Bronchoscopy 48 = Capnography or End Tidal CO2 205 = Cardiovascular Drugs (epinephrine, lidocaine, etc.) 11 = Cervical Collar/Backboard 12 = Closed Reduction(s) 52 = CT Facial 53 = CT Lumbar-Sacral Spine 54 = CT Pelvis 55 = CT Thoracic Spine 56 = CT Other 15 = Cutdown 16 = Cystogram 17 = Defibrillation 18 = Doppler Study 19 = ECG Monitor 20 = Fetal Heart Rate Monitor 58 = Fetal Heart Tone Auscultation 22 = Foley Catheter 220 = GI Drugs (droperidol, metoclopramide, etc.) 59 = HCG, Urine or Serum 60 = Hyperventilation 225 = Immunizations, Vaccinations 23 = Intracranial Pressure Monitor 24 = IV, Central Line 25 = IV, Intraosseous 226 = IV, Isotonic Crystalloids (NS, LR, etc.) 26 = IV, Peripheral 27 = K-wire or Steinman Pin Insertion 61 = MRI Abdomen 62 = MRI Brain 28 = MRI Cervical Spine 63 = MRI Chest 64 = MRI Lumbar or Sacral Spine 65 = MRI Other 66 = MRI Pelvis 67 = MRI Lumbar Spine 29 = Naso- or Oro-gastric Tube 207 = Nonsteroidal Anti-inflammatory Drugs (aspirin, ibuprofen, ketorolac, etc.) 46 = Other 31 = Oxygen 32 = Pericardiocentesis 68 = Pulse Oximetry 08 = Repeat H&H 34 = Shock Trouser 35 = Skeletal Traction 36 = Splinting 37 = Suture or Staple Laceration 38 = Temperature Monitor 39 = Thoracostomy, Needle 41 = Tongs or Halo 44 = Wound Care 45 = X-ray 100 – 199 = User-defined Interventions/Procedures

Section	Screen	Data Element Description	Collector Data Name	Definition
ED Data	F4.1	ED Procedure 2	**ED_PROC_02**	Emergency Department Procedure #2 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 3	**ED_PROC_03**	Emergency Department Procedure #3 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 4	**ED_PROC_04**	Emergency Department Procedure #4 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 5	**ED_PROC_05**	Emergency Department Procedure #5 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 6	**ED_PROC_06**	Emergency Department Procedure #6 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 7	**ED_PROC_07**	Emergency Department Procedure #7 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 8	**ED_PROC_08**	Emergency Department Procedure #8 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 9	**ED_PROC_09**	Emergency Department Procedure #9 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	ED Procedure 10	**ED_PROC_10**	Emergency Department Procedure #10 of 10. Order is not important for the maximum of ten procedures. See Emergency Department Procedure 1 for values.
ED Data	F4.1	CT Scan of Head Date	**CT_DATE**	CT Scan of Head Date, if applicable. Format is mm/dd/yyyy for Collector.
ED Data	F4.1	CT Scan of Head Month	**CT_DATE_M**	Month of CT Scan of the head. Values are from 1 and 12.
ED Data	F4.1	CT Scan of Head Day	**CT_DATE_D**	Day of CT Scan of the head. Valid values are from 1 to 31.
ED Data	F4.1	CT Scan of Head Year	**CT_DATE_Y**	Year of CT Scan of the head. Values are from 1980 to 2099.
ED Data	F4.1	CT Scan of Head Time	**CT_TIME**	The Time that a CT Scan was performed of the head if applicable.
ED Data	F4.1	CT Scan of Head Hour	**CT_TIME_H**	The hour that a CT Scan was performed of the head, if applicable. Valid values are from 0 and 23.
ED Data	F4.1	CT Scan of Head Minutes	**CT_TIME_M**	The minute that a CT Scan was performed of the head, if applicable. Values are from 0 and 59.
ED Data ***NEW ELEMENT***	F4.1	BAC Done	**BAC_DONE**	Indicates whether the patient had their Blood Alcohol Content (BAC) tested. 1 = Yes 2 = No
ED Data	F4.1	Blood Alcohol Content	**ETOH_BAC**	Blood alcohol level in **mg**/dL, as measure by the facility. Alcohol levels are frequently expressed as **grams**/dL; the legal limit for driving in Washington State in 1999 was .08 **g**/mL. If you multiply by 1000, you get 80 **mg**/dL, and you would enter 80. So a decimal is not entered or needed in this field. For

Section	Screen	Data Element Description	Collector Data Name	Definition
				example, if the value is .10 **g**/dL, enter 100. If the measured value is 1000 **mg**/dL or greater (or 1 **g**/dL or greater), enter 999; this situation should be *very* rare. Enter (U)nknown if BAC was not tested in your facility or if the test was done but the results are not known. (I)nappropriate should not be used.
ED Data	F4.1	Tox Screen Performed?	**TOX_DONE**	Indicates whether a Toxicology Screen was performed. 1 = Yes 2 = No
ED Data	F4.1	Tox Screen Results	**TOX_RESULT**	Results of the Toxicology Screen, if performed. 1 = Positive 2 = Negative
ED Data	F4.1	Tox Drug 1 Found	**TOX_DRUG**	1st of up to 3 drugs found. Do not include positive drug results secondary to drug administration by health care personnel during the resuscitation. Items 1 through 5 should be selected only once. Item 6 may be selected multiple times. 00 = None 01 = Opiates 02 = Cocaine 03 = Amphetamines 04 = Cannabis 05 = Barbiturates 06 = Other
ED Data	F4.1	Tox Drug 2 Found	**TOX_DRUG_2**	2nd of up to 3 drugs found. Do not include positive drug results secondary to drug administration by health care personnel during the resuscitation. Items 1 through 5 should be selected only once. Item 6 may be selected multiple times. See Tox Drug 1 for values.
ED Data	F4.1	Tox Drug 3 Found	**TOX_DRUG_3**	3rd of up to 3 drugs found. Do not include positive drug results secondary to drug administration by health care personnel during the resuscitation. Items 1 through 5 should be selected only once. Item 6 may be selected multiple times. See Tox Drug 1 for values.
ED Data	F4.1	Tox Drug Other Found	TOX_DRUG_O	Written name of the drug(s) found if "6=other" is chosen for tox drugs 1, 2, 3, or all. See also TOX_DRUG_1 through TOX_DRUG_3.
ED Data	F4.1	Elapsed Time (minutes) in Radiology	RAD_TIME	Minutes spent in radiology. Valid values are from 000 to 999.
ED Data	F4.2	Missed Cervical Spine Injury	MISSED_CS	Indicates whether there was a c-spine injury diagnosis at hospital discharge that was not indicated in the admission (ED) diagnoses. 1 = Yes (that is, the ED did not diagnose a c-spine injury that was diagnosed later in the patient's stay.) 2 = No (that is, a c-spine injury was diagnosed in the ED) (I)nappropriate = This patient did not have a c-spine injury noted in the discharge diagnosis. (U)nknown should not be used in this field.

Section	Screen	Data Element Description	Collector Data Name	Definition
ED Data	F4.2	No Operation for GSW to Abdomen	GUN_NONOP	Indicates whether the patient received non-operative management for a gunshot wound to the abdomen. 1 = Yes (received nonoperative management) 2 = No (received surgery) Enter (I)nappropriate if there was no gunshot wound to abdomen.
ED Data	F4.2	No Operation for SW to abdomen	STAB_NONOP	Indicates whether the patient received non-operative management for a stab wound to the abdomen. 1 = Yes 2 = No Enter (I)nappropriate if no stab wound to abdomen.
ED Data	F4.2	Pre-existing Condition 1	**PAST_MED_1**	Pre-existing condition 1 of up to 6. Refers to conditions evident prior to this hospital admission and documented in the medical record. 00 = None 01 = Gastrointestinal (GI) disease 02 = Cardiac *(such as, history of angina, significant arrhythmias, coronary artery bypass graft, angioplasty, stent placement, myocardial infarction , coronary artery disease, congestive heart failure, valvular disease, cardiomyoapthy, etc.)* 03 = Collagen/Vascular disease *(non-cardiac)* 04 = Obesity 05 = Drug Abuse 06 = Tobacco Use 07 = Seizure disorder 08 = Organic Brain Syndrome *(e.g. Alzheimer's Disease, Dementia)* 09 = Diabetes 10 = Respiratory *(such as chronic restrictive or obstructive pulmonary disease, pulmonary hypertension, etc.)* 11 = Cancer 12 = Cirrhosis *(or portal hypertension, hepatic failure, encephalopathy, or coma.)* 13 = Alcohol (ETOH) Abuse 14 = Previous Trauma 15 = Cerebral Vascular Accident (CVA or stroke) 16 = Hypertension 17 = Psychiatric 99 = Other
ED Data	F4.2	Pre-existing Condition 2	**PAST_MED_2**	Pre-existing condition 2. See Pre-existing Condition 1 for definition and values.
ED Data	F4.2	Pre-existing Condition 3	**PAST_MED_3**	Pre-existing condition 3. See Pre-existing Condition 1 for definition and values.
ED Data	F4.2	Pre-existing Condition 4	**PAST_MED_4**	Pre-existing condition 4. See Pre-existing Condition 1 for definition and values.
ED Data	F4.2	Pre-existing Condition 5	**PAST_MED_5**	Pre-existing condition 5. See Pre-existing Condition 1 for definition and values.
ED Data	F4.2	Pre-existing Condition 6	**PAST_MED_6**	Pre-existing condition 6. See Pre-existing Condition 1 for definition and values.
ED Data	F4.2	Pre-existing Condition Other	PAST_MED_O	Description of pre-existing condition(s) not included in the list of values for pre-existing conditions 1 through 6.
ED Data	F4.2	Eye Opening Sub-score of GCS in ED	**EYE_OPNG_E**	Sub-score of the Glasgow Coma Score (GCS) indicating patient *best* eye opening ***in the ED***. It is added to two other sub-scores to obtain the GCS in the ED. See also ED GCS (GCS_A).

Section	Screen	Data Element Description	Collector Data Name	Definition
				1 = None 2 = To Pain 3 = To Voice 4 = Spontaneous U = Unknown
ED Data	F4.2	Verbal Response Sub-score of GCS in ED	**VER_RESP_E**	Sub-score of the Glasgow Coma Score (GCS) indicating patient *best* verbal response ***in the ED***. It is added to two other sub-scores to obtain the GCS in the ED. See also ED GCS (GCS_A). 1 = None, intubated, or pharmacologically paralyzed 2 = Incomprehensible Sounds (under 2 yrs, Agitated/Restless) 3 = Inappropriate Words (under 2 yrs., Persistent Crying) 4 = Confused 5 = Oriented U = Unknown NOTE: If the patient was intubated or pharmacologically paralyzed enter 1 AND be sure to indicate the patient's status (intubated and/or paralyzed) below.
ED Data	F4.2	Motor Response Sub-score of GCS in ED	**MOT_RESP_E**	Sub-score of the Glasgow Coma Score (GCS) indicating the patient's *best* motor response ***in the ED***. It is added to two other sub-scores to obtain the ED GCS. See also discharge-GCS (GCS_A). 1 = None, or pharmacologically paralyzed 2 = Abnormal Extension 3 = Abnormal Flexion 4 = Withdraws to Pain 5 = Localizes Pain 6 = Obeys Commands U = Unknown Note: If the patient was pharmacologically paralyzed enter 1 AND be sure to indicate the patients paralyzed status below.
ED Data	F4.2	GCS in ED	**GCS_ A**	Glasgow Coma Score (GCS) is a widely used index that assesses the degree of coma in patients with craniocerebral injuries. The ED GCS is calculated by adding the sub-scores of three behavioral responses in the emergency department: eye opening (see EYE_OPNG_E), best verbal response (see VER_RESP_E), and best motor response (see MOT_RESP_E). Values range from 3 to 15.
ED Data	F4.2	Pediatric Trauma Score (PTS) on Admission	**PTS_A**	Pediatric Trauma Score in the emergency department. The Pediatric Trauma Score (PTS) combines physiologic and anatomic measures to assess the severity of childhood injury. One of three severity assignments is made for each of the six component variables: Size, Airway, Systolic BP, Central Nervous System, Skeletal, and Cutaneous. The associated point values are *summed* to yield the PTS. Value range from –6 (worst) to 12 (best). **Size** -1 = <10 kg (20 lbs.) 1 = 10 - 20 kg (20 lbs. to 40 lbs.) 2 = >20 kg (40 lbs.) **Airway** -1 = Unmaintainable 1 = Maintainable 2 = Normal **Systolic BP** -1 = <50 mm Hg 1 = 50-90 mm Hg

Section	Screen	Data Element Description	Collector Data Name	Definition
				2 = >90 mm Hg **Central Nervous System** -1 = Coma 1 = Obtunded 2 = Awake **Skeletal** -1 = Open fracture or multiple fractures 1 = Closed fracture 2 = None **Cutaneous** -1 = Major/penetrating 1 = Minor 2 = None
ED Data	F4.2	GCS Documented Every Hour	GCS_DOC	Indicates whether the Glasgow Coma Scale (GCS) was documented every hour. 1 = Yes 2 = No
ED Data	F4.2	Intubated at the Time of First GCS	**ED_INTUB**	Indicates whether the patient was intubated at the time of the Glasgow Coma Score (GCS) assessment recorded above. 1 = Yes 2 = No Important Note: If a patient is intubated, enter "1" for the GCS Verbal component recorded above. A GCS score cannot be accurately determined since the true verbal sub-score cannot be ascertained.
ED Data	F4.2	Paralyzed at the Time of First GCS	**ED_PRLYZ**	Indicates whether the patient was pharmacologically paralyzed at the time of the first Glasgow Coma Score (GCS) assessment recorded above. 1 = Yes 2 = No Important Note: If a patient is pharmacologically paralyzed, enter "1" for the GCS Verbal and Motor components recorded above. A GCS score cannot be accurately determined since the sub-scores cannot be ascertained.
ED Data	F4.3	Transfusion Within 24 Hours of ED Arrival	ED_TRANSF	Indicates whether the patient received a transfusion of platelets or fresh frozen plasma within 24 hours of arrival at emergency department, after having received <8 units of packed red blood cells or whole blood. 1 = Yes 2 = No
ED Data	F4.3	Pulse Rate (First ED)	**PULSE_E**	First pulse rate in beats per minute.
ED Data	F4.3	Respiratory Rate Controlled	**ASSI_ONV_E**	Indicates whether the patient's Respiratory Rate is controlled? Unknown and Inappropriate are not valid responses for this data element. 1 = Yes 2 = No
ED Data	F4.3	Controlled Respiratory Rate	**VENT_RAT_E**	The controlled rate of respiration if the respiratory rate is controlled. Enter Unknown if the respiration rate is controlled but the rate is not shown in the patient chart.

Section	Screen	Data Element Description	Collector Data Name	Definition
ED Data	F4.3	Respiratory Rate (First Spontaneous in ED)	**RESP_RAT_E**	The ***first*** number of unassisted respirations by the patient per minute. Does not include bagged or controlled ventilatory rates. If the patient's *unassisted* respiratory rate could not be recorded, enter "U" for unknown.
ED Data	F4.3	Systolic BP (First in ED)	**SYS_BP_E**	**First** Systolic Blood Pressure (BP) in ED measured in mm Hg.
ED Data	F4.3	Systolic BP (Lowest in ED)	**LSYS_BP_E**	Lowest systolic blood pressure in ED measured in mm Hg.
ED Data ***NEW ELEMENT***	F4.3	Hematocrit Level	HCT	Hematocrit level (percentage) for the patient. The percent of red blood cells to the blood volume.
ED Data	F4.3	Recorded Temperature	**TEMP_E**	***First*** temperature recorded by the health care professional. May be recorded in Fahrenheit or Centigrade. The unit must also be entered. See TEMP_FC_E.
ED Data	F4.3	Unit of Recorded Temperature	**TEMP_FC_E**	*Unit* of ***first*** recorded temperature. See TEMP_E. F = Fahrenheit C = Centigrade
ED Data	F4.3	Vital Signs Recorded Every Hour	VITALS_DOC	Indicates whether the vital signs were recorded every hour. 1 = Yes 2 = No
ED Data	F4.3	Revised Trauma Score (RTS) At ED	**RTS_A**	Note: This field is calculated by Collector if all the necessary data elements are entered. The Revised Trauma Score (RTS) is a physiologic severity score widely used in pre-hospital triage and based on measurements of vital signs (systolic blood pressure (SBP), respiratory rate (RR)) and a measurement of consciousness (Glasgow Coma Score (GCS)). The RTS provides a more accurate estimation of injury severity for patients with serious head injuries, and supplies more reliable predictions of outcome than its predecessor -- the Trauma Score. The ED RTS (RTS_{ed}) is automatically calculated by Collector if all data needed to compute it are known, as follows: **$RTS_{ed} = 0.9368 (GCS_c) + 0.7326 (SBP_c) + 0.2908 (RR_c)$**, where the subscript c refers to coded value. **GCS_{ed}** — **SBP_{ed}** — **RR_{ed}** — **Coded Value** 13 – 15 — >89 — 10 – 29 — 4 9 – 12 — 76 - 89 — >29 — 3 6 - 8 — 50 - 75 — 6 - 9 — 2 4 - 5 — 1 - 49 — 1 - 5 — 1 3 — 0 — 0 — 0 See also GCS_A, SYS_BP_E, and RESP_RAT_E.
ED Data	F4.3	Care Issue 1	**ISSUE_E_1**	1st of up to 3 care issues. Broad categories or specific events that may warrant review. Used to note a question or concern surrounding, for example, the patient's transport to the most appropriate facility, the call to a specialist, the OR's acceptance, etc. that could serve as an opportunity for further research or improvement. 00 = None 01 = Transport to Appropriate Facility *(under triage, or over triage; e.g., a Step 2 patient delivered to a Level IV facility despite the injury occurring within 30 minutes of a capable and available Level III facility)*

Section	Screen	Data Element Description	Collector Data Name	Definition
				02 = Emergency Physician Availability *(delay in placing call, or arrival of physician)* 03 = Trauma Team Activation *(e.g., under triage = patient eligible for a trauma team activation but does not receive one; or, over triage = patient not eligible for a trauma team activation, but receives one)* 04 = Trauma Team Arrival *(delay in arrival, or delay in placing call to team, or incomplete response of team)* 05 = General Surgeon *(delay in placing call, or uncertainty which surgeon should be called)* 06 = General Surgeon Arrival *(delay in arrival)* 07 = Specialist Call *(delay in placing call, or uncertainty which individual should be called)* 08 = Specialist Arrival *(delay in arrival)* 09 = Transfer Out to Appropriate Facility *(difficulty in determining most appropriate facility or physician, or obtaining verbal acceptance of transfer, etc.)* 10 = Delay in Transfer Out *(delay in decision to transfer out, delay in prehospital response to ED for transfer, poor weather conditions prolonging departure, etc.)* 11 = Met Transfer Criteria, Not Transferred Out *(patient likely to need resources unavailable at current hospital, yet not transferred to other acute care facility, etc.)* 12 = Blood Availability 13 = CT Scan Availability 14 = MRI Availability 15 = Diagnostic Test Results Availability 16 = Equipment Malfunction *(equipment needed for patient care not operating adequately)* 17 = Equipment Not Readily Available *(difficulty locating equipment, or needed equipment already in use)* 18 = Indicated Procedure Not Performed 19 = Indicated Diagnostic Test Not Ordered or Not Performed 20 = OR Acceptance 21 = Delay of Pain Medication 23 = Critical Care Bed Not Available 24 = Ward Bed Not Available 25 = Missed Injury *(significant injury documented on discharge from hospital that was not found during ED stay)* 26 = Unrecognized or Untreated Hypothermia 27 = Unrecognized or Untreated Hypovolemia 28 = Aspiration Due to C-Spine Restraints 31 = Cardiac Arrest Outside of ED (ie, CT) 32 = Chest Tube Displacement 33 = Intubation, Esophageal 34 = Inutbation, Mainstem 35 = Intubation, Tube Displacement 36 = Medication Not Available 37 = Neurovascular Changes After Splinting 38 = Other If '38, Other' is chosen, specify the care issue in the NOTES_CARE field.
ED Data	F4.3	Care Issue 2	**ISSUE_E_2**	Second of up to 3 ED care issues. See definition and values for ISSUE_E_1.
ED Data	F4.3	Care Issue 3	**ISSUE_E_3**	Third of up to 3 ED care issues. See definition and values for ISSUE_E_1.
ED Data ***NEW MEMO FIELD***	F4.3	Care Issue Memo	**NOTES_CARE**	Memo field to specify additional care issues not captured in ED Care Issue 1-3 fields. A care issue is defined as a condition arising *after* arrival in the emergency department which occurs as a result of the patient's treatment or events during

Section	Screen	Data Element Description	Collector Data Name	Definition
				the hospitalization, and requires additional medical treatment or affects the patient's length of stay. Care issues must be documented in the patient record by an attending or consulting *physician*. Suspected exacerbation of a pre-morbid condition should not be coded as a complication *unless specified by an attending or consulting physician.*
ED Data	F4.4	Emergency Department Physician	**ED_MD**	User-Defined code for the ED Physician. Values vary according to facility.
ED Data	F4.4	Time ED Physician Called	**ED_MD_C**	Time Emergency Department (ED) Physician was requested to see the patient. Note: If the physician was in the ED at the same time the patient arrived and *immediately* saw the patient, then the ED arrival time and time ED physician called could be the same. However, do not automatically enter the EDA arrival time here.
ED Data	F4.4	Hour ED Physician Called	**ED_MD_CH**	Hour emergency Department (ED) Physician was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes ED Physician Called	**ED_MD_CM**	Minutes Emergency Department (ED) Physician was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time ED Physician Arrived	**ED_MD_A**	Time Emergency Department (ED) Physician actually reached the patient.
ED Data	F4.4	Hour ED Physician Arrived	**ED_MD_AH**	Hour emergency Department (ED) Physician actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes ED Physician Arrived	**ED_MD_AM**	Minutes Emergency Department (ED) Physician actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.4	Trauma/General Surgeon	**TR_RES_MD**	User-Defined code for the trauma/general surgeon. Values vary depending on hospital.
ED Data	F4.4	Time Trauma/General Surgeon Called	**TR_RES_C**	Time trauma/general surgeon was requested to see the patient.
ED Data	F4.4	Hour Trauma/General Surgeon Called	**TR_RES_CH**	Hour trauma/general surgeon was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Trauma/General Surgeon Called	**TR_RES_CM**	Minutes trauma/general surgeon was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time Trauma/General Surgeon Arrived	**TR_RES_A**	Time trauma/general surgeon actually reached the patient.
ED Data	F4.4	Hour Trauma/General Surgeon Arrived	**TR_RES_AH**	Hour trauma/general surgeon actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Trauma/General Surgeon Arrived	**TR_RES_AM**	Minutes trauma/general surgeon actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.4	Anesthesiologist	ANES_MD	User-Defined code for the Anesthesiologist. Values vary depending on facility.

Section	Screen	Data Element Description	Collector Data Name	Definition
ED Data	F4.4	Time Anesthesiologist Called	ANES_C	Time Anesthesiologist was requested to see the patient.
ED Data	F4.4	Hour Anesthesiologist Called	ANES_CH	Hour Anesthesiologist was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Anesthesiologist Called	ANES_CM	Minutes Anesthesiologist was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time Anesthesiologist Arrived	ANES_A	Time Anesthesiologist actually reached the patient.
ED Data	F4.4	Hour Anesthesiologist Arrived	ANES_AH	Hour Anesthesiologist actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Anesthesiologist Arrived	ANES_AM	Minutes Anesthesiologist actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.4	Neurosurgeon	NEURO_MD	User-Defined code for Neurosurgeon. Values vary depending on facility.
ED Data	F4.4	Time Neurosurgeon Called	NEURO_C	Time Emergency Department (ED) Physician was requested to see the patient.
ED Data	F4.4	Hour Neurosurgeon Called	NEURO_CH	Hour Neurosurgeon was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Neurosurgeon Called	NEURO_CM	Minutes portion of time Neurosurgeon was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time Neurosurgeon Arrived	NEURO_A	Time Neurosurgeon actually reached the patient.
ED Data	F4.4	Hour Neurosurgeon Arrived	NEURO_AH	Hour Neurosurgeon actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Neurosurgeon Arrived	NEURO_AM	Minutes portion of time Neurosurgeon actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.4	Orthopedic Surgeon	ORTHO_MD	User-Defined code for Orthopedic Surgeon. Values vary depending on facility.
ED Data	F4.4	Time Orthopedic Surgeon Called	ORTHO_C	Time Orthopedic Surgeon was requested to see the patient.
ED Data	F4.4	Hour Orthopedic Surgeon Called	ORTHO_CH	Hour Orthopedic Surgeon was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Orthopedic Surgeon Called	ORTHO_CM	Minutes Orthopedic Surgeon was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time Orthopedic Surgeon Arrived	ORTHO_A	Time Orthopedic Surgeon actually reached the patient.
ED Data	F4.4	Hour Orthopedic Surgeon Arrived	ORTHO_AH	Hour Orthopedic Surgeon actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Orthopedic Surgeon	ORTHO_AM	Minutes Orthopedic Surgeon actually reached the patient. Valid values are from 0 to 59.

Section	Screen	Data Element Description	Collector Data Name	Definition
		Arrived		
ED Data	F4.4	Pediatric Surgeon	PEDIA_MD	User-Defined code for Pediatric Surgeon. Values vary depending on facility.
ED Data	F4.4	Time Pediatric Surgeon Called	PEDIA_C	Time Pediatric Surgeon was requested to see the patient.
ED Data	F4.4	Hour Pediatric Surgeon Called	PEDIA_CH	Hour Pediatric Surgeon was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Pediatric Surgeon Called	PEDIA_CM	Minutes Pediatric Surgeon was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time Pediatric Surgeon Arrived	PEDIA_A	Time Pediatric Surgeon actually reached the patient.
ED Data	F4.4	Hour Pediatric Surgeon Arrived	PEDIA_AH	Hour Pediatric Surgeon actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Pediatric Surgeon Arrived	PEDIA_AM	Minutes Pediatric Surgeon actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.4	Consulting Physician	CNSLT_MD	User-Defined code for the Consulting Physician. Values vary according to facility.
ED Data	F4.4	Time Consulting Physician Called	CNSLT_C	Time Consulting Physician was requested to see the patient.
ED Data	F4.4	Hour Consulting Physician Called	CNSLT_CH	Hour Consulting Physician was requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Consulting Physician Called	CNSLT_CM	Minutes Consulting Physician was requested to see the patient. Valid values are from 0 to 59.
ED Data	F4.4	Time Consulting Physician Arrived	CNSLT_A	Time Consulting Physician actually reached the patient.
ED Data	F4.4	Hour Consulting Physician Arrived	CNSLT_AH	Hour Consulting Physician actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes Consulting Physician Arrived	CNSLT_AM	Minutes Consulting Physician actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.4	ENT/Plastic Surgeon	ENT_MD	User-Defined code for ENT/Plastic Surgeon. Values vary depending on facility.
ED Data	F4.4	Time ENT/Plastic Surgeon Called	ENT_C	Time ENT/Plastic Surgeon requested to see the patient.
ED Data	F4.4	Hour ENT/Plastic Surgeon Called	ENT_CH	Hour portion of time ENT/Plastic Surgeon requested to see the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes ENT/Plastic Surgeon Called	ENT_CM	Minutes portion of time ENT/Plastic Surgeon requested to see the patient. Valid values are from 0 to 59.

Section	Screen	Data Element Description	Collector Data Name	Definition
ED Data	F4.4	Time ENT/Plastic Surgeon Arrived	ENT_A	Time ENT/Plastic Surgeon actually reached the patient.
ED Data	F4.4	Hour ENT/Plastic Surgeon Arrived	ENT_AH	Hour portion of time ENT/Plastic Surgeon actually reached the patient. Valid values are from 0 to 23.
ED Data	F4.4	Minutes ENT/Plastic Surgeon Arrived	ENT_AM	Minutes portion of time ENT/Plastic Surgeon actually reached the patient. Valid values are from 0 to 59.
ED Data	F4.5	Emergency Department Discharge (EDD) Date	**EDD_DATE**	Date that the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor, transferred to another facility, discharged, or died. If the patient was a direct admit to the hospital, the date will default to the EDA date so the ED length of stay will be zero.
ED Data	F4.5	Emergency Department Discharge (EDD) Month	**EDD_DATE_M**	Month that the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor, transferred to another facility, discharged, or died.
ED Data	F4.5	Emergency Department Discharge (EDD) Day	**EDD_DATE_D**	Day that the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor, transferred to another facility, discharged, or died.
ED Data	F4.5	Emergency Department Discharge (EDD) Year	**EDD_DATE_Y**	Year that the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor, transferred to another facility, discharged, or died.
ED Data	F4.5	Emergency Department Discharge (EDD) Time	**EDD_TIME**	Time that the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor, transferred to another facility, discharged, or died. Initial radiological work-up (CT scan X-rays, angiography, etc.) is included in ED time. If the patient was a direct admit to the hospital, the time will default to the EDA time so the ED length of stay will be zero.
ED Data	F4.5	Emergency Department Discharge (EDD)	**EDD_TIME_H**	Hour portion of the time the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor; transferred to another facility, discharged, or died. Initial radiological work-up (CT scan X-rays, angiography, etc.) is included in ED time. Valid values range from 0 to 23
ED Data	F4.5	Emergency Department Discharge (EDD) Minutes	**EDD_TIME_M**	Minutes portion of the time the patient left the ED resuscitation area for final disposition, without returning to the ED, and was either admitted to OR, ICU, or floor, transferred to another facility, discharged, or died. Initial radiological work-up (CT scan X-rays, angiography, etc.) is included in ED time. Valid values are from 0 to 59.
ED Data	F4.5	Emergency Department Discharge Disposition	**EDD_DISP**	Emergency Department Discharge Disposition. 01 = OR (Operating Room) 02 = Ward or Floor; *providing routine nursing care and staffing levels* 03 = Other Acute Care Facility *(**transfers** to other hospitals; when used, the "receiving hospital ID" must also be entered. See REC_FAC_ID.)* 04 = ICU/CCU 05 = Other In-house 06 = Home 07 = Skilled Nursing Facility (SNF) - External 08 = Intermediate Care Facility (ICF) 09 = Expired (Died)

Section	Screen	Data Element Description	Collector Data Name	Definition
				10 = Other (Out of Facility, POV Transfers) *This field is only used when the patient is transferred to somewhere other than listed above. This field should rarely be used. When used, EDD_DISP_O should also be entered.* 11 = Pediatric Ward 12 = Pediatric ICU 13 = Progressive Care Unit (eg, Stepdown, Telemetry, Monitored Unit) 14 = Short Stay Unit (eg, Ambulatory Treatment Unit, Observation Unit, <24 Hour Unit) – If patient is subsequently admitted, use 05=Other In-House 15 = Inpatient Psychiatry 16 = Jail, Police Custody 17 = In House SNF (Skilled Nursing Facility) 18 = Foster Care Note: A patient is "transferred" (choice 3) to another hospital if sent by ambulance. A patient sent by private vehicle or other means is not a "transfer" for the purposes of the Trauma Registry. However, if you are including these records in your registry, please code the ED disposition as 10=Other and not 3=Other ACF, and specify POV Transfer in the Emergency Department Other Discharge Disposition (EDD_DISP_O) field.
ED Data	F4.5	Emergency Department Other Discharge Disposition	EDD_DISP_O	Text description of the ED discharge disposition if '10 = Other' is chosen. See EDD_DISP.
ED Data	F4.5	Receiving Facility ID if Transferred from ED	**REC_FAC_ID**	ID of the hospital where the patient went if the patient was transferred from the ED to another hospital. See REF_ID for defined values.
ED Data	F4.5	Previously Seen in ED	SEEN_PREV	Indicates whether a patient was evaluated *and discharged* from an ED (i.e. *not admitted* to the hospital) who subsequently returned and was admitted to the hospital within 72 hours of initial evaluation. 1 = Yes 2 = No
ED Data	F4.5	Admitting Service	ADMIT_ED	Admitting Service 01 = Trauma 02 = Neurosurgery 03 = Orthopedic Surgery 04 = ENT/Plastic Surgery 05 = Thoracic Surgery 06 = Pediatric Surgery 07 = Pediatrics 08 = Other Surgical Service 09 = Other Non-surgical Service
ED Data	F4.5	Other Admitting Service	ADMIT_ED_O	Text name and/or description of admitting service if not listed in ADMIT_ED.
ED Data	F4.5	Attending M.D. in ED	ED_ATT_MD	ID of Attending/Admitting Physician. This is a user-defined field and varies between hospitals.
ED Data	F4.5	Left ED Intubated	ART_AIRWAY	Indicates whether the patient left the ED intubated. If intubation was not required, enter "I". 1 = Yes 2 = No
ED Data	F4.5	Laparotomy Performed	NO_LAPAROT	Indicates that a laparotomy was performed within 2 hours of EDA. If a laparotomy was not required, enter "I".

Section	Screen	Data Element Description	Collector Data Name	Definition
		Within 2 Hours if Required		1 = Yes 2 = No
ED Data	F4.5	Procedure Code of Laparotomy	LAP_PROC	The operative procedure code of the type of laparotomy that was performed. If a laparotomy was not required, enter "I".
ED Data	F4.6	ED Memo	NOTES_ED	Ten lines designated for a description of patient's ED information.
Opers./Procs.	F5.1	Surgery Performed	**SURG_DONE**	Indicates whether the patient had surgery. 1 = Yes 2 = No
Opers./Procs.	F5.1	Operation 1 Arrival Date	**OP1A_DATE**	Date the patient arrived in the surgical suite for operation 1.
Opers./Procs.	F5.1	Operation 1 Arrival Month	**OP1A_D_M**	Month the patient arrived in the surgical suite for operation 1. Valid values are from 1 to 12.
Opers./Procs.	F5.1	Operation 1 Arrival Day	**OP1A_D_D**	Day the patient arrived in the surgical suite for operation 1. Valid values are from 1 to 31.
Opers./Procs.	F5.1	Operation 1 Arrival Year	**OP1A_D_Y**	Year the patient arrived in the surgical suite for operation 1. Valid values are from 1980 to 2099.
Opers./Procs.	F5.1	Operation 1 Arrival Time	**OP1A_TIME**	Time that the patient arrived in the surgical suite for operation 1.
Opers./Procs.	F5.1	Operation 1 Hour of Arrival Time	**OP1A_T_H**	Hour that the patient arrived in the surgical suite for operation 1. Valid values are from 0 to 23.
Opers./Procs.	F5.1	Operation 1 Minutes of Arrival Time	**OP1A_T_M**	Minutes portion of time that the patient arrived in the surgical suite for operation 1. Valid values are from 0 to 59.
Opers./Procs.	F5.1	Operation 1 Start Date	**OP1S_DATE**	Date operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.1	Operation 1 Start Month	**OP1S_D_M**	Month operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Opers./Procs.	F5.1	Operation 1 Start Day	**OP1S_D_D**	Day that operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Opers./Procs.	F5.1	Operation 1 Start Year	**OP1S_D_Y**	Year operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Opers./Procs.	F5.1	Operation 1 Start Time	**OP1S_TIME**	Time operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.1	Operation 1 Hour of Start Time	**OP1S_T_H**	Hour operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 and 23.
Opers./Procs.	F5.1	Operation 1 Minutes of Start Time	**OP1S_T_M**	Minutes portion of the time operation 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 to 59.
Opers./Procs.	F5.1	Operation 1 End Date	**OP1E_DATE**	Date operation 1 was finished.

Section	Screen	Data Element Description	Collector Data Name	Definition
Opers./Procs.	F5.1	Operation 1 End Month	**OP1E_D_M**	Month operation 1 was finished. Valid values are from 1 to 12.
Opers./Procs.	F5.1	Operation 1 End Day	**OP1E_D_D**	Day operation 1 was finished. Valid values are from 1 to 31.
Opers./Procs.	F5.1	Operation 1 End Year	**OP1E_D_Y**	Year operation 1 was finished. Valid values are from 1980 to 2099.
Opers./Procs.	F5.1	Operation 1 End Time	**OP1E_TIME**	Time operation 1 was finished.
Opers./Procs.	F5.1	Operation 1 Hour of End Time	**OP1E_T_H**	Hour operation 1 was finished. Valid values are from 0 to 23.
Opers./Procs.	F5.1	Operation 1 Minutes of End Time	**OP1E_T_M**	Minutes portion of time operation 1 was finished. Valid values are from 0 to 59.
Opers./Procs.	F5.1	Operation 1 Surgeon ID	OP1_SURG	User-defined ID number of the operating surgeon for operation 1. Values vary by hospital.
Opers./Procs.	F5.1	Operation 1 Procedure 1	**OP1_PROC1**	1st of up to 10 operative procedures for operation 1, using standard ICD-9-CM Procedure coding. **Operations on the Nervous System** 01.24 Craniotomy, Other 01.25 Craniectomy, Other 01.31 Incision, Cerebral Meninges 01.39 Incision, Brain, Other 01.59 Excision, Brain, Other 02.02 Elevation, Skull Fracture Fragments 02.12 Repair, Cerebral Meninges, Other 02.39 Insertion, Ventricular Shunt to Other 02.93 Implantation, Neurostimulator 02.94 Insertion/Replacement, Skull Tongs/Halo Traction 02.99 Operation, Skull/Brain/Meninges, Other 03.09 Exploration/Decompression, Spinal Canal, Other 03.4 Excision/Destruction, Spinal Cord/Meninges 03.53 Repair, Fx, Vertebra 03.99 Operation, Spinal Cord/Canal, Other 04.07 Excision/Avulsion, Cranial/Peripheral Nerve, Other 04.3 Suture, Cranial/Peripheral Nerve, Other 04.49 Decompression/Lysis, Periph Nerve/Ganglion, Other 04.74 Anastomosis, Cranial/Peripheral Nerve, Other 04.79 Neuroplasty, Other **Operations on the Endocrine System** Defined by each hospital **Operations on the Eye** 08.61 Reconstruction, Eyelid, Skin Flap/Graft 08.70 Reconstruction, Eyelid, Not Otherwise Specified 08.81 Repair, Eyelid/Eyebrow, Linear 08.84 Repair, Eyelid Margin, Full Thickness 08.85 Repair, Eyelid, Full Thickness, Other 11.51 Suture, Cornea 14.30 Repair of Retinal Tear 16.49 Enucleation, Eyeball, Other 16.89 Repair, Eyeball/Orbit Injury, Other **Operations on the Ear** 18.4 Suture, External Ear 18.71 Construction, Ear Auricle 18.79 Repair, External Ear, Other **Operations on the Nose, Mouth, Pharynx** 21.71 Reduction, Fx, Nose, Closed 21.72 Reduction, Fx, Nose, Open 21.81 Suture, Nose 22.64 Sphenoidectomy

Section	Screen	Data Element Description	Collector Data Name	Definition
				22.79 Repair, Nasal Sinus, Other 23.5 Implantation, Tooth 24.32 Suture, Gum 24.7 Application, Orthodontic Appliance 25.51 Suture, Tongue 27.51 Suture, Lip **Operations on the Respiratory System** 31.1 Tracheostomy, Temporary 31.29 Tracheostomy, Permanent 31.64 Repair, Larynx 31.71 Suture, Trachea 32.3 Resection, Lung, Segment 32.5 Pneumonectomy, Complete 33.43 Suture, Lung 33.49 Repair, Lung, Other 34.02 Thoracotomy, Exploratory 34.04 Insertion, Intercostal Drainage Catheter 34.09 Incision, Pleura, Other 34.71 Suture, Chest Wall 34.82 Suture, Diaphragm 34.84 Repair, Diaphragm, Other **Operations on the Cardiovascular System** **Operations on Valves and Septa** 35.71 Other, Unspecified Repair of Atrial Septal Defect 35.72 Other, Unspecified Repair - Ventricular Septal Defect **Operations on Vessels of Heart** 36.99 Other Operations on Vessels of Heart **Other Operations on Heart and Pericardium** 37.12 Pericardiotomy 37.4 Repair, Heart/Pericardium 37.91 Cardiac Massage, Open Chest **Incision, Excision, and Occlusion of Vessels** 38.38 Resection/Anastomosis, Lower Limb Artery 38.44 Resection/Replacement, Aorta 38.45 Resection/Replacement, Thoracic Vessel, Other 38.64 Excision, Aorta, Not Otherwise Specified 38.7 Plication, Vena Cava 38.80 Occlusion, Blood Vessel, Unspecified 38.81 Occlusion, Intracranial Vessel 38.82 Occlusion, Head/Neck Vessel, Other 38.83 Occlusion, Upper Limb Vessel 38.84 Occlusion, Aorta 38.85 Occlusion, Thoracic Vessel 38.86 Occlusion, Abdomen Artery 38.87 Occlusion, Abdominal Vessel 38.88 Occlusion, Lower Limb Artery 38.89 Occlusion, Lower Limb Vein 38.91 Arterial Catheterization 38.93 Venous Catherization, Not Elsewhere Classified **Other Operations on Vessels** 39.30 Suture, Vessel, Unspecified 39.31 Suture, Artery 39.32 Suture, Vein 39.59 Repair, Vessel, Other 39.98 Hemorrhage Control, Vessel, Not Otherwise Spec **Operations on the Hemic and Lymphatic System** 41.5 Splenectomy, Total 41.95 Repair, Spleen **Operations on the Digestive System** 43.1 Gastrostomy, Temporary 43.19 Other Gastrostomy

Section	Screen	Data Element Description	Collector Data Name	Definition
				44.61 Suture, Stomach 45.33 Local Excision of Lesion/Tissue Small Intestine 45.62 Resection, Small Intestine, Partial, Other 45.71 Resection, Large Intestine, Multiple Segmental 45.79 Excision, Large Intestine, Partial 45.94 Anastomosis, Intestine, Large-to-Large 46.10 Colostomy, Not Otherwise Specified 46.39 Enterostomy, Other 46.72 Suture, Duodenum 46.73 Suture, Small Intestine 46.75 Suture, Large Intestine 46.79 Repair, Intestine, Other 48.66 Resection, Rectum, Hartmann 50.11 Biopsy, Liver, Percutaneous 50.29 Destruction, Liver, Other 50.61 Repair, Liver 51.22 Cholecystectomy, Total 52.09 Pancreatotomy, Other 52.59 Pancreatectomy, Partial 52.95 Repair, Pancreas, Other 53.80 Repair, Diaphragmatic Hernia 54.11 Laparotomy, Exploratory 54.19 Laparotomy, Other 54.61 Reclosure Postoperative Disruption/Abdominal Wall 54.63 Suture, Abdomen Wall, Other 54.72 Repair, Abdomen Wall, Other 54.75 Repair, Mesentery 54.92 Removal, Foreign Body, Peritoneal Cavity **Operations on the Urinary System** 55.51 Nephroureterectomy 57.81 Suture, Bladder 57.89 Repair, Bladder, Other 57.94 Insertion, Urinary Catheter, Indwelling **Operations on the Male Genital Organ** Defined by each hospital **Operations on the Female Genital Organ** Defined by each hospital **Obstetrical Procedures** 74.99 Caesarean Section, Other/Unspecified **Operations on the Musculoskeletal System** **Operations on Facial Bones and Joints** 76.72 Reduction, Fx, Malar/Zygoma, Open 76.73 Reduction, Fx, Maxilla, Closed 76.74 Reduction, Fx, Maxilla, Open 76.75 Reduction, Fx, Mandible, Closed 76.76 Reduction, Fx, Mandible, Open 76.77 Reduction, Fx, Alveolus, Open 76.79 Reduction, Fx, Face, Open, Other **Incision, Excision, and Division of Other Bones** Defined by each hospital **Other Operations on Bones, Except Facial Bones** 78.07 Bone Graft, Tibia/Fibula 78.27 Epiphyseal Stapling, Tibia/Fibula 78.55 Internal Fixation, Femur, w/o Reduction 78.57 Internal Fixation, Tibia/Fibula, w/o Reduction **Reduction of Fracture and Dislocation** **Closed Reduction of Fracture with/without Internal Fixation** 79.01 Reduction, Fx, Humerus, w/o Int Fix, Closed 79.02 Reduction, Fx, Radius/Ulna, w/o Int Fix, Closed 79.03 Reduction, Fx, Carp/Metacarp, w/o Int Fix, Closed 79.04 Reduction, Fx, Phal, Hand, w/o Int Fix, Closed

Section	Screen	Data Element Description	Collector Data Name	Definition
				79.05 Reduction, Fx, Femur, w/o Int Fix, Closed 79.06 Reduction, Fx, Tibia/Fibula, w/o Int Fix, Closed 79.07 Reduction, Fx, Tars/Metatars, w/o Int Fix, Closed 79.08 Reduction, Fx, Phal, Foot, w/o Int Fix, Closed 79.09 Reduction, Fx, Other Spec, w/o Int Fix, Closed 79.11 Reduction, Fx, Humerus, w/ Int Fix, Closed 79.12 Reduction, Fx, Radius/Ulna, w/ Int Fix, Closed 79.13 Reduction, Fx, Carp/Metacarp, w/ Int Fix, Closed 79.14 Reduction, Fx, Phal, Hand, w/ Int Fix, Closed 79.15 Reduction, Fx, Femur, w/ Int Fix, Closed 79.16 Reduction, Fx, Tibia/Fibula, w/ Int Fix, Closed 79.17 Reduction, Fx, Tars/Metatars, w/ Int Fix, Closed 79.18 Reduction, Fx, Phal, Foot, w/ Int Fix, Closed 79.19 Reduction, Fx, Other Spec, w/ Int Fix, Closed **Open Reduction of Fracture with/without Internal Fixation** 79.21 Reduction, Fx, Humerus, w/o Int Fix, Open 79.22 Reduction, Fx, Radius/Ulna, w/o Int Fix, Open 79.23 Reduction, Fx, Carp/Metacarp, w/o Int Fix, Open 79.24 Reduction, Fx, Phal, Hand, w/o Int Fix, Open 79.25 Reduction, Fx, Femur, w/o Int Fix, Open 79.26 Reduction, Fx, Tibia/Fibula, w/o Int Fix, Open 79.27 Reduction, Fx, Tars/Metatars, w/o Int Fix, Open 79.28 Reduction, Fx, Phal, Foot, w/o Int Fix, Open 79.29 Reduction, Fx, Other Spec, w/o Int Fix, Open 79.31 Reduction, Fx, Humerus, w/ Int Fix, Open 79.32 Reduction, Fx, Radius/Ulna, w/ Int Fix, Open 79.33 Reduction, Fx, Carp/Metacarp, w/ Int Fix, Open 79.34 Reduction, Fx, Phal, Hand, w/ Int Fix, Open 79.35 Reduction, Fx, Femur, w/ Int Fix, Open 79.36 Reduction, Fx, Tibia/Fibula, w/ Int Fix, Open 79.37 Reduction, Fx, Tars/Metatars, w/ Int Fix, Open 79.38 Reduction, Fx, Phal, Foot, w/ Int Fix, Open 79.39 Reduction, Fx, Other Spec, w/ Int Fix, Open **Closed/Open Reduction of Separated Epiphysis** Defined by each hospital **Debridement of Open Fracture Site** 79.61 Debridement, Fx, Humerus, Open 79.62 Debridement, Fx, Radius/Ulna, Open 79.63 Debridement, Fx, Carp/Metacarp, Open 79.64 Debridement, Fx, Phal, Hand, Open 79.65 Debridement, Fx, Femur, Open 79.66 Debridement, Fx, Tibia/Fibula, Open 79.67 Debridement, Fx, Tars/Metatars, Open 79.68 Debridement, Fx, Phal, Foot, Open 79.69 Debridement, Fx, Other Spec, Open **Closed Reduction of Dislocation** 79.71 Reduction, Disloc, Shoulder, Closed 79.72 Reduction, Disloc, Elbow, Closed 79.73 Reduction, Disloc, Wrist, Closed 79.74 Reduction, Disloc, Hand/Finger, Closed 79.75 Reduction, Disloc, Hip, Closed 79.76 Reduction, Disloc, Knee, Closed 79.77 Reduction, Disloc, Ankle, Closed 79.78 Reduction, Disloc, Foot/Toe, Closed 79.79 Reduction, Disloc, Other Spec, Closed **Open Reduction of Dislocation** 79.81 Reduction, Disloc, Shoulder, Open 79.82 Reduction, Disloc, Elbow, Open 79.83 Reduction, Disloc, Wrist, Open 79.84 Reduction, Disloc, Hand/Finger, Open 79.85 Reduction, Disloc, Hip, Open

Section	Screen	Data Element Description	Collector Data Name	Definition
				79.86 Reduction, Disloc, Knee, Open 79.87 Reduction, Disloc, Ankle, Open 79.88 Reduction, Disloc, Foot/Toe, Open 79.89 Reduction, Disloc, Other Spec, Open **Unspecified Operation on Bone Injury** Defined by each hospital **Incision and Excision of Joint Structures** 80.26 Arthroscopy, Knee 80.46 Division, Capsule/Ligament/Cartilage, Knee 80.5 Excision/Destruction, Intervertebral Disc 80.51 Excision of intervertebral Disc **Repair and Plastic Operation on Joint Structures** 81.01 Fusion, Fx, Spine, Atlas/Axis 81.02 Fusion, Fx, Spine, Other Cervical 81.03 Fusion, Fx, Spine, Thoracic 81.04 Fusion, Fx, Spine, Thoracolumbar w/ Harrington Rod 81.05 Fusion, Fx, Spine, Other Thoracolumbar 81.06 Fusion, Fx, Spine, Lumbar 81.07 Fusion, Fx, Spine, Lumbosacral 81.08 Refusion, Fx, Spine 81.09 Fusion, Fx, Spine 81.45 Repair, Cruciate Ligaments, Other 81.46 Repair, Collateral Ligaments, Other 81.47 Repair, Knee, Other 81.51 Replacement, Hip, Total w/ Methyl Methacrylate 81.83 Other Repair of Shoulder 81.96 Repair, Joint, Other **Operations on Muscle, Tendon, and Fascia of Hand** 82.41 Suture, Hand, Tendon Sheath **Operations on Muscle, Tendon, Fascia, & Bursa, Except Hand** 83.09 Other Incision of Soft Tissue 83.14 Fasciotomy 83.61 Suture, Tendon Sheath 83.63 Repair, Rotator Cuff 83.64 Suture, Tendon, Other 83.73 Reattachment, Tendon 83.88 Plastic Operation, Tendon, Other **Other Procedures on Musculoskeletal System** 84.05 Amputation, Through Forearm 84.07 Amputation, Through Humerus 84.11 Amputation, Toe 84.13 Disarticulation of Ankle 84.15 Amputation, Below Knee, Other 84.17 Amputation, Above Knee 84.21 Reattachment, Thumb 84.22 Reattachment, Finger 84.23 Reattachment, Forearm, Wrist, Hand 84.24 Reattachment, Arm 84.25 Reattachment, Toe 84.26 Reattachment, Foot 84.27 Reattachment, Leg/Ankle 84.28 Reattachment, Thigh 84.29 Reattachment, Other Extremity **Operations on the Integumentary System** 86.05 Incision, Skin/Subcutaneous Tissue, w/ FB Removal 86.09 Incision, Skin/Subcutaneous Tissue, Other 86.22 Debridement, Skin/Subcutaneous Wound 86.28 Nonexcisional Debridement of Wound, Infection, Burn 86.3 Excision/Destruction, Skin/Subcut Tissue, Other 86.51 Replantation, Scalp 86.59 Suture, Skin/Subcutaneous Tissue, Other Sites

Section	Screen	Data Element Description	Collector Data Name	Definition
				86.60 Free Skin Graft, Not Otherwise Specified 86.66 Homograft to Skin 86.69 Skin Graft to Other Sites, Other 86.89 Repair, Skin/Subcutaneous Tissue, Other **Diagnostic and Nonsurgical Procedures** 87.76 Retrograde Cystourethrogram 87.77 Other Cystogram 93.51 Application, Cast, Plaster Jacket 93.53 Application, Cast, Other 93.55 Wiring, Dental 93.59 Immobilization/Pressure/Attention, Wound, Other 96.59 Irrigation, Wound, Other 98.29 Removal, Foreign Body, Lower Limb, w/o Incision
Opers./Procs.	F5.1	Operation 1 Procedure 2	**OP1_PROC2**	2nd operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 3	**OP1_PROC3**	3rd operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 4	**OP1_PROC4**	4th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 5	**OP1_PROC5**	5th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 6	**OP1_PROC6**	6th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 7	**OP1_PROC7**	7th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 8	**OP1_PROC8**	8th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 9	**OP1_PROC9**	9th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Procedure 10	**OP1_PROC10**	10th operative procedure for operation 1, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.1	Operation 1 Disposition	**OP1_DISP**	Operation 1 disposition. Refers to the disposition of the patient following post-anesthesia recovery (PAR). 01 = OR 02 = Ward/Floor 04 = ICU/CCU 05 = Short Stay/Discharged, (e.g. ambulatory treatment unit, observation unit, <24 hour unit) 06 = Expired (Died) 07 = Other In-House 08 = Other (Out of Facility) 09 = Other Acute Care Facility 10 = Peds 11 = Peds, ICU 12 = Progressive Care Unit (e.g., stepdown, telemetry, monitored unit) 13 = Home 14 = Jail, Police Custody
Opers./Procs.	F5.2	Operation 2	**OP2A_DATE**	Date the patient arrived in the surgical suite for operation 2.

Section	Screen	Data Element Description	Collector Data Name	Definition
		Arrival Date		
Opers./Procs.	F5.2	Operation 2 Arrival Month	**OP2A_D_M**	Month the patient arrived in the surgical suite for operation 2. Valid values are from 1 to 12.
Opers./Procs.	F5.2	Operation 2 Arrival Day	**OP2A_D_D**	Day the patient arrived in the surgical suite for operation 2. Valid values are from 1 to 31.
Opers./Procs.	F5.2	Operation 2 Arrival Year	**OP2A_D_Y**	Year the patient arrived in the surgical suite for operation 2. Valid values are from 1980 to 2099.
Opers./Procs.	F5.2	Operation 2 Arrival Time	**OP2A_TIME**	Time that the patient arrived in the surgical suite for operation 2.
Opers./Procs.	F5.2	Operation 2 Hour of Arrival Time	**OP2A_T_H**	Hour that the patient arrived in the surgical suite for operation 2. Valid values are from 0 to 23.
Opers./Procs.	F5.2	Operation 2 Minutes of Arrival Time	**OP2A_T_M**	Minutes portion of time that the patient arrived in the surgical suite for operation 2. Valid values are from 0 to 59.
Opers./Procs.	F5.2	Operation 2 Start Date	**OP2S_DATE**	Date operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.2	Operation 2 Start Month	**OP2S_D_M**	Month operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Opers./Procs.	F5.2	Operation 2 Start Day	**OP2S_D_D**	Day that operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Opers./Procs.	F5.2	Operation 2 Start Year	**OP2S_D_Y**	Year operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Opers./Procs.	F5.2	Operation 2 Start Time	**OP2S_TIME**	Time operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.2	Operation 2 Hour of Start Time	**OP2S_T_H**	Hour operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 and 23.
Opers./Procs.	F5.2	Operation 2 Minutes of Start Time	**OP2S_T_M**	Minutes portion of the time operation 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 to 59.
Opers./Procs.	F5.2	Operation 2 End Date	**OP2E_DATE**	Date operation 2 was finished.
Opers./Procs.	F5.2	Operation 2 End Month	**OP2E_D_M**	Month operation 2 was finished. Valid values are from 1 to 12.
Opers./Procs.	F5.2	Operation 2 End Day	**OP2E_D_D**	Day operation 2 was finished. Valid values are from 1 to 31.
Opers./Procs.	F5.2	Operation 2 End Year	**OP2E_D_Y**	Year operation 2 was finished. Valid values are from 1980 to 2099.
Opers./Procs.	F5.2	Operation 2 End Time	**OP2E_TIME**	Time operation 2 was finished.
Opers./Procs.	F5.2	Operation 2 Hour of End Time	**OP2E_T_H**	Hour operation 2 was finished. Valid values are from 0 to 23.
Opers./Procs.	F5.2	Operation 2 Minutes of End Time	**OP2E_T_M**	Minutes portion of time operation 2 was finished. Valid values are from 0 to 59.

Section	Screen	Data Element Description	Collector Data Name	Definition
Opers./Procs.	F5.2	Operation 2 Surgeon ID	OP2_SURG	User-defined ID number of the operating surgeon for operation 2. Values vary by hospital.
Opers./Procs.	F5.2	Operation 2 Procedure 1	**OP2_PROC1**	1st operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 2	**OP2_PROC2**	2nd operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 3	**OP2_PROC3**	3rd operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 4	**OP2_PROC4**	4th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 5	**OP2_PROC5**	5th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 6	**OP2_PROC6**	6th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 7	**OP2_PROC7**	7th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 8	**OP2_PROC8**	8th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 9	**OP2_PROC9**	9th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Procedure 10	**OP2_PROC10**	10th operative procedure for operation 2, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.2	Operation 2 Disposition	**OP2_DISP**	Operation 2 disposition. Refers to the disposition of the patient following post-anesthesia recovery (PAR). See OP1_DISP for values.
Opers./Procs.	F5.3	Operation 3 Arrival Date	**OP3A_DATE**	Date the patient arrived in the surgical suite for operation 3.
Opers./Procs.	F5.3	Operation 3 Arrival Month	**OP3A_D_M**	Month the patient arrived in the surgical suite for operation 3. Valid values are from 1 to 12.
Opers./Procs.	F5.3	Operation 3 Arrival Day	**OP3A_D_D**	Day the patient arrived in the surgical suite for operation 3. Valid values are from 1 to 31.
Opers./Procs.	F5.3	Operation 3 Arrival Year	**OP3A_D_Y**	Year the patient arrived in the surgical suite for operation 3. Valid values are from 1980 to 2099.
Opers./Procs.	F5.3	Operation 3 Arrival Time	**OP3A_TIME**	Time that the patient arrived in the surgical suite for operation 3.
Opers./Procs.	F5.3	Operation 3 Hour of Arrival Time	**OP3A_T_H**	Hour that the patient arrived in the surgical suite for operation 3. Valid values are from 0 to 23.
Opers./Procs.	F5.3	Operation 3 Minutes of Arrival Time	**OP3A_T_M**	Minutes portion of time that the patient arrived in the surgical suite for operation 3. Valid values are from 0 to 59.
Opers./Procs.	F5.3	Operation 3 Start Date	**OP3S_DATE**	Date operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.3	Operation 3 Start Month	**OP3S_D_M**	Month operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative

Section	Screen	Data Element Description	Collector Data Name	Definition
				anesthesia). Valid values are from 1 to 12.
Opers./Procs.	F5.3	Operation 3 Start Day	**OP3S_D_D**	Day that operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Opers./Procs.	F5.3	Operation 3 Start Year	**OP3S_D_Y**	Year operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Opers./Procs.	F5.3	Operation 3 Start Time	**OP3S_TIME**	Time operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.3	Operation 3 Hour of Start Time	**OP3S_T_H**	Hour operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 and 23.
Opers./Procs.	F5.3	Operation 3 Minutes of Start Time	**OP3S_T_M**	Minutes portion of the time operation 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 to 59.
Opers./Procs.	F5.3	Operation 3 End Date	**OP3E_DATE**	Date operation 3 was finished.
Opers./Procs.	F5.3	Operation 3 End Month	**OP3E_D_M**	Month operation 3 was finished. Valid values are from 1 to 12.
Opers./Procs	F5.3	Operation 3 End Day	**OP3E_D_D**	Day operation 3 was finished. Valid values are from 1 to 31.
Opers./Procs.	F5.3	Operation 3 End Year	**OP3E_D_Y**	Year operation 3 was finished. Valid values are from 1980 to 2099.
Opers./Procs.	F5.3	Operation 3 End Time	**OP3E_TIME**	Time operation 3 was finished.
Opers./Procs.	F5.3	Operation 3 Hour of End Time	**OP3E_T_H**	Hour operation 3 was finished. Valid values are from 0 to 23.
Opers./Procs.	F5.3	Operation 3 Minutes of End Time	**OP3E_T_M**	Minutes portion of time operation 3 was finished. Valid values are from 0 to 59.
Opers./Procs.	F5.3	Operation 3 Surgeon ID	OP3_SURG	User-defined ID number of the operating surgeon for operation 3. Values vary by hospital.
Opers./Procs.	F5.3	Operation 3 Procedure 1	**OP3_PROC1**	1st operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 2	**OP3_PROC2**	2nd operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 3	**OP3_PROC3**	3rd operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 4	**OP3_PROC4**	4th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 5	**OP3_PROC5**	5th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 6	**OP3_PROC6**	6th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 7	**OP3_PROC7**	7th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.

Section	Screen	Data Element Description	Collector Data Name	Definition
Opers./Procs.	F5.3	Operation 3 Procedure 8	**OP3_PROC8**	8th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 9	**OP3_PROC9**	9th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.3	Operation 3 Procedure 10	**OP3_PROC10**	10th operative procedure for operation 3, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs	F5.3	Operation 3 Disposition	**OP3_DISP**	Operation 3 disposition. Refers to the disposition of the patient following post-anesthesia recovery (PAR). See OP1_DISP for values.
Opers./Procs	F5.4	Operation 4 Arrival Date	**OP4A_DATE**	Date the patient arrived in the surgical suite for operation 4.
Opers./Procs.	F5.4	Operation 4 Arrival Month	**OP4A_D_M**	Month the patient arrived in the surgical suite for operation 4. Valid values are from 1 to 12.
Opers./Procs	F5.4	Operation 4 Arrival Day	**OP4A_D_D**	Day the patient arrived in the surgical suite for operation 4. Valid values are from 1 to 31.
Opers./Procs.	F5.4	Operation 4 Arrival Year	**OP4A_D_Y**	Year the patient arrived in the surgical suite for operation 4. Valid values are from 1980 to 2099.
Opers./Procs.	F5.4	Operation 4 Arrival Time	**OP4A_TIME**	Time that the patient arrived in the surgical suite for operation 4.
Opers./Procs.	F5.4	Operation 4 Hour of Arrival Time	**OP4A_T_H**	Hour that the patient arrived in the surgical suite for operation 4. Valid values are from 0 to 23.
Opers./Procs	F5.4	Operation 4 Minutes of Arrival Time	**OP4A_T_M**	Minutes portion of time that the patient arrived in the surgical suite for operation 4. Valid values are from 0 to 59.
Opers./Procs	F5.4	Operation 4 Start Date	**OP4S_DATE**	Date operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs	F5.4	Operation 4 Start Month	**OP4S_D_M**	Month operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Opers./Procs.	F5.4	Operation 4 Start Day	**OP4S_D_D**	Day that operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Opers./Procs.	F5.4	Operation 4 Start Year	**OP4S_D_Y**	Year operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Opers./Procs.	F5.4	Operation 4 Start Time	**OP4S_TIME**	Time operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs	F5.4	Operation 4 Hour of Start Time	**OP4S_T_H**	Hour operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 and 23.
Opers./Procs.	F5.4	Operation 4 Minutes of Start Time	**OP4S_T_M**	Minutes portion of the time operation 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 to 59.
Opers./Procs	F5.4	Operation 4 End Date	**OP4E_DATE**	Date operation 4 was finished.
Opers./Procs	F5.4	Operation 4	**OP4E_D_M**	Month operation 4 was finished. Valid values are from 1 to 12.

Section	Screen	Data Element Description	Collector Data Name	Definition
		End Month		
Opers./Procs	F5.4	Operation 4 End Day	**OP4E_D_D**	Day operation 4 was finished. Valid values are from 1 to 31.
Opers./Procs.	F5.4	Operation 4 End Year	**OP4E_D_Y**	Year operation 4 was finished. Valid values are from 1980 to 2099.
Opers./Procs.	F5.4	Operation 4 End Time	**OP4E_TIME**	Time operation 4 was finished.
Opers./Procs	F5.4	Operation 4 Hour of End Time	**OP4E_T_H**	Hour operation 4 was finished. Valid values are from 0 to 23.
Opers./Procs.	F5.4	Operation 4 Minutes of End Time	**OP4E_T_M**	Minutes portion of time operation 4 was finished. Valid values are from 0 to 59.
Opers./Procs.	F5.4	Operation 4 Surgeon ID	OP4_SURG	User-defined ID number of the operating surgeon for operation 4. Values vary by hospital.
Opers./Procs.	F5.4	Operation 4 Procedure 1	**OP4_PROC1**	1st operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 2	**OP4_PROC2**	2nd operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 3	**OP4_PROC3**	3rd operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 4	**OP4_PROC4**	4th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 5	**OP4_PROC5**	5th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 6	**OP4_PROC6**	6th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 7	**OP4_PROC7**	7th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 8	**OP4_PROC8**	8th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.4	Operation 4 Procedure 9	**OP4_PROC9**	9th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs	F5.4	Operation 4 Procedure 10	**OP4_PROC10**	10th operative procedure for operation 4, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs	F5.4	Operation 4 Disposition	**OP4_DISP**	Operation 4 disposition. Refers to the disposition of the patient following post-anesthesia recovery (PAR). See OP1_DISP for values.
Opers./Procs.	F5.5	Operation 5 Arrival Date	**OP5A_DATE**	Date the patient arrived in the surgical suite for operation 5.
Opers./Procs.	F5.5	Operation 5 Arrival Month	**OP5A_D_M**	Month the patient arrived in the surgical suite for operation 5. Valid values are from 1 to 12.
Opers./Procs.	F5.5	Operation 5 Arrival Day	**OP5A_D_D**	Day the patient arrived in the surgical suite for operation 5. Valid values are from 1 to 31.
Opers./Procs.	F5.5	Operation 5 Arrival Year	**OP5A_D_Y**	Year the patient arrived in the surgical suite for operation 5. Valid values are from 1980 to 2099.

Section	Screen	Data Element Description	Collector Data Name	Definition
Opers./Procs.	F5.5	Operation 5 Arrival Time	**OP5A_TIME**	Time that the patient arrived in the surgical suite for operation 5.
Opers./Procs	F5.5	Operation 5 Hour of Arrival Time	**OP5A_T_H**	Hour that the patient arrived in the surgical suite for operation 5. Valid values are from 0 to 23.
Opers./Procs.	F5.5	Operation 5 Minutes of Arrival Time	**OP5A_T_M**	Minutes portion of time that the patient arrived in the surgical suite for operation 5. Valid values are from 0 to 59.
Opers./Procs.	F5.5	Operation 5 Start Date	**OP5S_DATE**	Date operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs.	F5.5	Operation 5 Start Month	**OP5S_D_M**	Month operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Opers./Procs	F5.5	Operation 5 Start Day	**OP5S_D_D**	Day that operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Opers./Procs.	F5.5	Operation 5 Start Year	**OP5S_D_Y**	Year operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Opers./Procs.	F5.5	Operation 5 Start Time	**OP5S_TIME**	Time operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia).
Opers./Procs	F5.5	Operation 5 Hour of Start Time	**OP5S_T_H**	Hour operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 and 23.
Opers./Procs.	F5.5	Operation 5 Minutes of Start Time	**OP5S_T_M**	Minutes portion of the time operation 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 0 to 59.
Opers./Procs.	F5.5	Operation 5 End Date	**OP5E_DATE**	Date operation 5 was finished.
Opers./Procs	F5.5	Operation 5 End Month	**OP5E_D_M**	Month operation 5 was finished. Valid values are from 1 to 12.
Opers./Procs.	F5.5	Operation 5 End Day	**OP5E_D_D**	Day operation 5 was finished. Valid values are from 1 to 31.
Opers./Procs.	F5.5	Operation 5 End Year	**OP5E_D_Y**	Year operation 5 was finished. Valid values are from 1980 to 2099.
Opers./Procs.	F5.5	Operation 5 End Time	**OP5E_TIME**	Time operation 5 was finished.
Opers./Procs.	F5.5	Operation 5 Hour of End Time	**OP5E_T_H**	Hour operation 5 was finished. Valid values are from 0 to 23.
Opers./Procs.	F5.5	Operation 5 Minutes of End Time	**OP5E_T_M**	Minutes portion of time operation 5 was finished. Valid values are from 0 to 59.
Opers./Procs.	F5.5	Operation 5 Surgeon ID	OP5_SURG	User-defined ID number of the operating surgeon for operation 5. Values vary by hospital.
Opers./Procs.	F5.5	Operation 5 Procedure 1	**OP5_PROC1**	1st operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5 Procedure 2	**OP5_PROC2**	2nd operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5	**OP5_PROC3**	3rd operative procedure for operation 5, using standard ICD-9-CM Procedure

Section	Screen	Data Element Description	Collector Data Name	Definition
		Procedure 3		coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5 Procedure 4	**OP5_PROC4**	4th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs	F5.5	Operation 5 Procedure 5	**OP5_PROC5**	5th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5 Procedure 6	**OP5_PROC6**	6th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5 Procedure 7	**OP5_PROC7**	7th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5 Procedure 8	**OP5_PROC8**	8th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs	F5.5	Operation 5 Procedure 9	**OP5_PROC9**	9th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs.	F5.5	Operation 5 Procedure 10	**OP5_PROC10**	10th operative procedure for operation 5, using standard ICD-9-CM Procedure coding. See Operation 1 Procedure 1 (OP1_PROC1) for values.
Opers./Procs	F5.5	Operation 5 Disposition	**OP5_DISP**	Operation 5 disposition. Refers to the disposition of the patient following post-anesthesia recovery (PAR). See OP1_DISP for values.
Opers./Procs.	F5.6	Abdominal Surgery Performed Late	ABD_SURG	Indicates whether abdominal surgery was performed > 24 hours after arrival, if applicable. Enter "I" if no abdominal surgery was performed. 1 = Yes 2 = No
Opers./Procs.	F5.6	Thoracic Surgery Performed Late	THRC_SURG	Indicates whether thoracic surgery was performed > 24 hours after arrival, if applicable. Enter "I" if no thoracic surgery was performed. 1 = Yes 2 = No
Opers./Procs.	F5.6	Vascular Surgery Performed Late	VASC_SURG	Indicates whether vascular surgery was performed > 24 hours after arrival, if applicable. Enter "I" if no vascular surgery was performed. 1 = Yes 2 = No
Opers./Procs.	F5.6	Cranial Surgery Performed Late	CRAN_SURG	Indicates whether cranial surgery was performed > 24 hours after arrival, if applicable. Enter "I" if no cranial surgery was performed. 1 = Yes 2 = No
Opers./Procs.	F5.6	Unplanned Return To OR	UNPLAND_OR	Indicates whether there was an unplanned return to OR within 48 hours of admission. If 'yes', the body region of the operation must also be entered. See also BODY_REG. 1 = Yes 2 = No
Opers./Procs.	F5.6	Body Region of Operation	BODY_REG	Indicates what region of the body in which an unplanned operation was performed. See also UNPLAND_OR.

Section	Screen	Data Element Description	Collector Data Name	Definition
				1 = Vascular 2 = Abdominal 3 = Orthopedic 4 = Neurologic 5 = Thoracic 6 = Other
Opers/Procs.	F5.7	OR Memo	NOTES_OR	Ten lines designated for a description of patient's OR information.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 1	PR_01_PR	1st of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. **Operations on the Nervous System** 01.24 Craniotomy, Other 01.25 Craniectomy, Other 01.31 Incision, Cerebral Meninges 01.39 Incision, Brain, Other 01.59 Excision, Brain, Other 02.02 Elevation, Skull Fracture Fragments 02.12 Repair, Cerebral Meninges, Other 02.39 Insertion, Ventricular Shunt to Other 02.93 Implantation, Neurostimulator 02.94 Insertion/Replacement, Skull Tongs/Halo Traction 02.99 Operation, Skull/Brain/Meninges, Other 03.09 Exploration/Decompression, Spinal Canal, Other 03.4 Excision/Destruction, Spinal Cord/Meninges 03.53 Repair, Fx, Vertebra 03.99 Operation, Spinal Cord/Canal, Other 04.07 Excision/Avulsion, Cranial/Peripheral Nerve, Other 04.3 Suture, Cranial/Peripheral Nerve, Other 04.49 Decompression/Lysis, Periph Nerve/Ganglion, Other 04.74 Anastomosis, Cranial/Peripheral Nerve, Other 04.79 Neuroplasty, Other **Operations on the Endocrine System** Defined by each hospital **Operations on the Eye** 08.61 Reconstruction, Eyelid, Skin Flap/Graft 08.70 Reconstruction, Eyelid, Not Otherwise Specified 08.81 Repair, Eyelid/Eyebrow, Linear 08.84 Repair, Eyelid Margin, Full Thickness 08.85 Repair, Eyelid, Full Thickness, Other 11.51 Suture, Cornea 14.30 Repair of Retinal Tear 16.49 Enucleation, Eyeball, Other 16.89 Repair, Eyeball/Orbit Injury, Other **Operations on the Ear** 18.4 Suture, External Ear 18.71 Construction, Ear Auricle 18.79 Repair, External Ear, Other **Operations on the Nose, Mouth, Pharynx** 21.71 Reduction, Fx, Nose, Closed 21.72 Reduction, Fx, Nose, Open 21.81 Suture, Nose 22.64 Sphenoidectomy 22.79 Repair, Nasal Sinus, Other 23.5 Implantation, Tooth 24.32 Suture, Gum 24.7 Application, Orthodontic Appliance 25.51 Suture, Tongue 27.51 Suture, Lip **Operations on the Respiratory System** 31.1 Tracheostomy, Temporary

Section	Screen	Data Element Description	Collector Data Name	Definition
				31.29 Tracheostomy, Permanent 31.64 Repair, Larynx 31.71 Suture, Trachea 32.3 Resection, Lung, Segment 32.5 Pneumonectomy, Complete 33.43 Suture, Lung 33.49 Repair, Lung, Other 34.02 Thoracotomy, Exploratory 34.04 Insertion, Intercostal Drainage Catheter 34.09 Incision, Pleura, Other 34.71 Suture, Chest Wall 34.82 Suture, Diaphragm 34.84 Repair, Diaphragm, Other **Operations on the Cardiovascular System** **Operations on Valves and Septa** 35.71 Other, Unspecified Repair of Atrial Septal Defect 35.72 Other, Unspecified Repair - Ventricular Septal Defect **Operations on Vessels of Heart** 36.99 Other Operations on Vessels of Heart **Other Operations on Heart and Pericardium** 37.12 Pericardiotomy 37.4 Repair, Heart/Pericardium 37.91 Cardiac Massage, Open Chest **Incision, Excision, and Occlusion of Vessels** 38.38 Resection/Anastomosis, Lower Limb Artery 38.44 Resection/Replacement, Aorta 38.45 Resection/Replacement, Thoracic Vessel, Other 38.64 Excision, Aorta, Not Otherwise Specified 38.7 Plication, Vena Cava 38.80 Occlusion, Blood Vessel, Unspecified 38.81 Occlusion, Intracranial Vessel 38.82 Occlusion, Head/Neck Vessel, Other 38.83 Occlusion, Upper Limb Vessel 38.84 Occlusion, Aorta 38.85 Occlusion, Thoracic Vessel 38.86 Occlusion, Abdomen Artery 38.87 Occlusion, Abdominal Vessel 38.88 Occlusion, Lower Limb Artery 38.89 Occlusion, Lower Limb Vein 38.91 Arterial Catheterization 38.93 Venous Catherization, Not Elsewhere Classified **Other Operations on Vessels** 39.30 Suture, Vessel, Unspecified 39.31 Suture, Artery 39.32 Suture, Vein 39.59 Repair, Vessel, Other 39.98 Hemorrhage Control, Vessel, Not Otherwise Spec **Operations on the Hemic and Lymphatic System** 41.5 Splenectomy, Total 41.95 Repair, Spleen **Operations on the Digestive System** 43.1 Gastrostomy, Temporary 43.19 Other Gastrostomy 44.61 Suture, Stomach 45.33 Local Excision of Lesion/Tissue Small Intestine 45.62 Resection, Small Intestine, Partial, Other 45.71 Resection, Large Intestine, Multiple Segmental 45.79 Excision, Large Intestine, Partial 45.94 Anastomosis, Intestine, Large-to-Large 46.10 Colostomy, Not Otherwise Specified 46.39 Enterostomy, Other

Section	Screen	Data Element Description	Collector Data Name	Definition
				46.72 Suture, Duodenum 46.73 Suture, Small Intestine 46.75 Suture, Large Intestine 46.79 Repair, Intestine, Other 48.66 Resection, Rectum, Hartmann 50.11 Biopsy, Liver, Percutaneous 50.29 Destruction, Liver, Other 50.61 Repair, Liver 51.22 Cholecystectomy, Total 52.09 Pancreatotomy, Other 52.59 Pancreatectomy, Partial 52.95 Repair, Pancreas, Other 53.80 Repair, Diaphragmatic Hernia 54.11 Laparotomy, Exploratory 54.19 Laparotomy, Other 54.61 Reclosure Postoperative Disruption/Abdominal Wall 54.63 Suture, Abdomen Wall, Other 54.72 Repair, Abdomen Wall, Other 54.75 Repair, Mesentery 54.92 Removal, Foreign Body, Peritoneal Cavity **Operations on the Urinary System** 55.51 Nephroureterectomy 57.81 Suture, Bladder 57.89 Repair, Bladder, Other 57.94 Insertion, Urinary Catheter, Indwelling **Operations on the Male Genital Organ** Defined by each hospital **Operations on the Female Genital Organ** Defined by each hospital **Obstetrical Procedures** 74.99 Caesarean Section, Other/Unspecified **Operations on the Musculoskeletal System** **Operations on Facial Bones and Joints** 76.72 Reduction, Fx, Malar/Zygoma, Open 76.73 Reduction, Fx, Maxilla, Closed 76.74 Reduction, Fx, Maxilla, Open 76.75 Reduction, Fx, Mandible, Closed 76.76 Reduction, Fx, Mandible, Open 76.77 Reduction, Fx, Alveolus, Open 76.79 Reduction, Fx, Face, Open, Other **Incision, Excision, and Division of Other Bones** Defined by each hospital **Other Operations on Bones, Except Facial Bones** 78.07 Bone Graft, Tibia/Fibula 78.27 Epiphyseal Stapling, Tibia/Fibula 78.55 Internal Fixation, Femur, w/o Reduction 78.57 Internal Fixation, Tibia/Fibula, w/o Reduction **Reduction of Fracture and Dislocation** **Closed Reduction of Fracture with/without Internal Fixation** 79.01 Reduction, Fx, Humerus, w/o Int Fix, Closed 79.02 Reduction, Fx, Radius/Ulna, w/o Int Fix, Closed 79.03 Reduction, Fx, Carp/Metacarp, w/o Int Fix, Closed 79.04 Reduction, Fx, Phal, Hand, w/o Int Fix, Closed 79.05 Reduction, Fx, Femur, w/o Int Fix, Closed 79.06 Reduction, Fx, Tibia/Fibula, w/o Int Fix, Closed 79.07 Reduction, Fx, Tars/Metatars, w/o Int Fix, Closed 79.08 Reduction, Fx, Phal, Foot, w/o Int Fix, Closed 79.09 Reduction, Fx, Other Spec, w/o Int Fix, Closed 79.11 Reduction, Fx, Humerus, w/ Int Fix, Closed 79.12 Reduction, Fx, Radius/Ulna, w/ Int Fix, Closed 79.13 Reduction, Fx, Carp/Metacarp, w/ Int Fix, Closed

Section	Screen	Data Element Description	Collector Data Name	Definition
				79.14 Reduction, Fx, Phal, Hand, w/ Int Fix, Closed 79.15 Reduction, Fx, Femur, w/ Int Fix, Closed 79.16 Reduction, Fx, Tibia/Fibula, w/ Int Fix, Closed 79.17 Reduction, Fx, Tars/Metatars, w/ Int Fix, Closed 79.18 Reduction, Fx, Phal, Foot, w/ Int Fix, Closed 79.19 Reduction, Fx, Other Spec, w/ Int Fix, Closed **Open Reduction of Fracture with/without Internal Fixation** 79.21 Reduction, Fx, Humerus, w/o Int Fix, Open 79.22 Reduction, Fx, Radius/Ulna, w/o Int Fix, Open 79.23 Reduction, Fx, Carp/Metacarp, w/o Int Fix, Open 79.24 Reduction, Fx, Phal, Hand, w/o Int Fix, Open 79.25 Reduction, Fx, Femur, w/o Int Fix, Open 79.26 Reduction, Fx, Tibia/Fibula, w/o Int Fix, Open 79.27 Reduction, Fx, Tars/Metatars, w/o Int Fix, Open 79.28 Reduction, Fx, Phal, Foot, w/o Int Fix, Open 79.29 Reduction, Fx, Other Spec, w/o Int Fix, Open 79.31 Reduction, Fx, Humerus, w/ Int Fix, Open 79.32 Reduction, Fx, Radius/Ulna, w/ Int Fix, Open 79.33 Reduction, Fx, Carp/Metacarp, w/ Int Fix, Open 79.34 Reduction, Fx, Phal, Hand, w/ Int Fix, Open 79.35 Reduction, Fx, Femur, w/ Int Fix, Open 79.36 Reduction, Fx, Tibia/Fibula, w/ Int Fix, Open 79.37 Reduction, Fx, Tars/Metatars, w/ Int Fix, Open 79.38 Reduction, Fx, Phal, Foot, w/ Int Fix, Open 79.39 Reduction, Fx, Other Spec, w/ Int Fix, Open **Closed/Open Reduction of Separated Epiphysis** Defined by each hospital **Debridement of Open Fracture Site** 79.61 Debridement, Fx, Humerus, Open 79.62 Debridement, Fx, Radius/Ulna, Open 79.63 Debridement, Fx, Carp/Metacarp, Open 79.64 Debridement, Fx, Phal, Hand, Open 79.65 Debridement, Fx, Femur, Open 79.66 Debridement, Fx, Tibia/Fibula, Open 79.67 Debridement, Fx, Tars/Metatars, Open 79.68 Debridement, Fx, Phal, Foot, Open 79.69 Debridement, Fx, Other Spec, Open **Closed Reduction of Dislocation** 79.71 Reduction, Disloc, Shoulder, Closed 79.72 Reduction, Disloc, Elbow, Closed 79.73 Reduction, Disloc, Wrist, Closed 79.74 Reduction, Disloc, Hand/Finger, Closed 79.75 Reduction, Disloc, Hip, Closed 79.76 Reduction, Disloc, Knee, Closed 79.77 Reduction, Disloc, Ankle, Closed 79.78 Reduction, Disloc, Foot/Toe, Closed 79.79 Reduction, Disloc, Other Spec, Closed **Open Reduction of Dislocation** 79.81 Reduction, Disloc, Shoulder, Open 79.82 Reduction, Disloc, Elbow, Open 79.83 Reduction, Disloc, Wrist, Open 79.84 Reduction, Disloc, Hand/Finger, Open 79.85 Reduction, Disloc, Hip, Open 79.86 Reduction, Disloc, Knee, Open 79.87 Reduction, Disloc, Ankle, Open 79.88 Reduction, Disloc, Foot/Toe, Open 79.89 Reduction, Disloc, Other Spec, Open **Unspecified Operation on Bone Injury** Defined by each hospital **Incision and Excision of Joint Structures** 80.26 Arthroscopy, Knee

Section	Screen	Data Element Description	Collector Data Name	Definition
				80.46 Division, Capsule/Ligament/Cartilage, Knee 80.5 Excision/Destruction, Intervertebral Disc 80.51 Excision of intervertebral Disc **Repair and Plastic Operation on Joint Structures** 81.01 Fusion, Fx, Spine, Atlas/Axis 81.02 Fusion, Fx, Spine, Other Cervical 81.03 Fusion, Fx, Spine, Thoracic 81.04 Fusion, Fx, Spine, Thoracolumbar w/ Harrington Rod 81.05 Fusion, Fx, Spine, Other Thoracolumbar 81.06 Fusion, Fx, Spine, Lumbar 81.07 Fusion, Fx, Spine, Lumbosacral 81.08 Refusion, Fx, Spine 81.09 Fusion, Fx, Spine 81.45 Repair, Cruciate Ligaments, Other 81.46 Repair, Collateral Ligaments, Other 81.47 Repair, Knee, Other 81.51 Replacement, Hip, Total w/ Methyl Methacrylate 81.83 Other Repair of Shoulder 81.96 Repair, Joint, Other **Operations on Muscle, Tendon, and Fascia of Hand** 82.41 Suture, Hand, Tendon Sheath **Operations on Muscle, Tendon, Fascia, & Bursa, Except Hand** 83.09 Other Incision of Soft Tissue 83.14 Fasciotomy 83.61 Suture, Tendon Sheath 83.63 Repair, Rotator Cuff 83.64 Suture, Tendon, Other 83.73 Reattachment, Tendon 83.88 Plastic Operation, Tendon, Other **Other Procedures on Musculoskeletal System** 84.05 Amputation, Through Forearm 84.07 Amputation, Through Humerus 84.11 Amputation, Toe 84.13 Disarticulation of Ankle 84.15 Amputation, Below Knee, Other 84.17 Amputation, Above Knee 84.21 Reattachment, Thumb 84.22 Reattachment, Finger 84.23 Reattachment, Forearm, Wrist, Hand 84.24 Reattachment, Arm 84.25 Reattachment, Toe 84.26 Reattachment, Foot 84.27 Reattachment, Leg/Ankle 84.28 Reattachment, Thigh 84.29 Reattachment, Other Extremity **Operations on the Integumentary System** 86.05 Incision, Skin/Subcutaneous Tissue, w/ FB Removal 86.09 Incision, Skin/Subcutaneous Tissue, Other 86.22 Debridement, Skin/Subcutaneous Wound 86.28 Nonexcisional Debridement of Wound, Infection, Burn 86.3 Excision/Destruction, Skin/Subcut Tissue, Other 86.51 Replantation, Scalp 86.59 Suture, Skin/Subcutaneous Tissue, Other Sites 86.60 Free Skin Graft, Not Otherwise Specified 86.66 Homograft to Skin 86.69 Skin Graft to Other Sites, Other 86.89 Repair, Skin/Subcutaneous Tissue, Other **Diagnostic and Nonsurgical Procedures** 87.76 Retrograde Cystourethrogram 87.77 Other Cystogram 93.51 Application, Cast, Plaster Jacket

Section	Screen	Data Element Description	Collector Data Name	Definition
				93.53 Application, Cast, Other 93.55 Wiring, Dental 93.59 Immobilization/Pressure/Attention, Wound, Other 96.59 Irrigation, Wound, Other 98.29 Removal, Foreign Body, Lower Limb, w/o Incision
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 1 Location	PR_01_LC	Location of Other In-House Procedure 1. 01 = ICU/CCU 02 = Ward/Floor 03 = Radiology/Angiography 04 = Special Procedure Unit 05 = Short Stay Unit 06 = Pediatrics 07 = Pediatrics ICU 08 = Progressive Care Unit 09 = Other In-house Location (excluding OR) I = Inappropriate U = Unknown
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 1 Start Date	PR_01_S_DATE	Date Other In-House Procedure 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 1 Start Month	PR_01_S_DM	Month Other In-House Procedure 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 1 Start Day	PR_01_S_DD	Day Other In-House Procedure 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 1 Start Year	PR_01_S_DY	Year Other In-House Procedure 1 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 2	PR_02_PR	2nd of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)***	F6.1	Other In-House Procedure 2 Location	PR_02_LC	Location of Other In-House Procedure 2. See Other In-House Procedure 1 Location (PR_01_LC) for values.

Section	Screen	Data Element Description	Collector Data Name	Definition
NEW ELEMENT				
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 2 Start Date	PR_02_S_DATE	Date Other In-House Procedure 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 2 Start Month	PR_02_S_DM	Month Other In-House Procedure 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 2 Start Day	PR_02_S_DD	Day Other In-House Procedure 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 2 Start Year	PR_02_S_DY	Year Other In-House Procedure 2 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 3	PR_03_PR	3rd of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 3 Location	PR_03_LC	Location of Other In-House Procedure 3. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 3 Start Date	PR_03_S_DATE	Date Other In-House Procedure 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 3 Start Month	PR_03_S_DM	Month Other In-House Procedure 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW***	F6.1	Other In-House Procedure 3 Start Day	PR_03_S_DD	Day Other In-House Procedure 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.

Section	Screen	Data Element Description	Collector Data Name	Definition
SECTION) ***NEW ELEMENT***				
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 3 Start Year	PR_03_S_DY	Year Other In-House Procedure 3 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 4	PR_04_PR	4th of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 4 Location	PR_04_LC	Location of Other In-House Procedure 4. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 4 Start Date	PR_04_S_DATE	Date Other In-House Procedure 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 4 Start Month	PR_04_S_DM	Month Other In-House Procedure 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 4 Start Day	PR_04_S_DD	Day Other In-House Procedure 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 4 Start Year	PR_04_S_DY	Year Other In-House Procedure 4 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 5	PR_05_PR	5th of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.

Section	Screen	Data Element Description	Collector Data Name	Definition
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 5 Location	PR_05_LC	Location of Other In-House Procedure 5. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 5 Start Date	PR_05_S_DATE	Date Other In-House Procedure 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 5 Start Month	PR_05_S_DM	Month Other In-House Procedure 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 5 Start Day	PR_05_S_DD	Day Other In-House Procedure 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 5 Start Year	PR_05_S_DY	Year Other In-House Procedure 5 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 6	PR_06_PR	6th of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 6 Location	PR_06_LC	Location of Other In-House Procedure 6. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 6 Start Date	PR_06_S_DATE	Date Other In-House Procedure 6 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)***	F6.1	Other In-House Procedure 6 Start Month	PR_06_S_DM	Month Other In-House Procedure 6 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.

Section	Screen	Data Element Description	Collector Data Name	Definition
NEW ELEMENT				
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 6 Start Day	PR_06_S_DD	Day Other In-House Procedure 6 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 6 Start Year	PR_06_S_DY	Year Other In-House Procedure 6 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 7	PR_07_PR	7th of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 7 Location	PR_07_LC	Location of Other In-House Procedure 7. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 7 Start Date	PR_07_S_DATE	Date Other In-House Procedure 7 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 7 Start Month	PR_07_S_DM	Month Other In-House Procedure 7 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 7 Start Day	PR_07_S_DD	Day Other In-House Procedure 7 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 7 Start Year	PR_07_S_DY	Year Other In-House Procedure 7 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW***	F6.1	Other In-House Procedure 8	PR_08_PR	8th of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.

Section	Screen	Data Element Description	Collector Data Name	Definition
SECTION) ***NEW ELEMENT***				
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 8 Location	PR_08_LC	Location of Other In-House Procedure 8. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 8 Start Date	PR_08_S_DATE	Date Other In-House Procedure 8 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 8 Start Month	PR_08_S_DM	Month Other In-House Procedure 8 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 8 Start Day	PR_08_S_DD	Day Other In-House Procedure 8 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 8 Start Year	PR_08_S_DY	Year Other In-House Procedure 8 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 9	PR_09_PR	9th of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 9 Location	PR_09_LC	Location of Other In-House Procedure 9. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 9 Start Date	PR_09_S_DATE	Date Other In-House Procedure 9 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.

Section	Screen	Data Element Description	Collector Data Name	Definition
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 9 Start Month	PR_09_S_DM	Month Other In-House Procedure 9 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 9 Start Day	PR_09_S_DD	Day Other In-House Procedure 9 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 9 Start Year	PR_09_S_DY	Year Other In-House Procedure 9 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 10	PR_10_PR	10^{th} of up to 10 Other In-House Procedures, using standard ICD-9-CM Procedure coding. See Other In-House Procedure 1 (PR_01_PR) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 10 Location	PR_10_LC	Location of Other In-House Procedure 10. See Other In-House Procedure 1 Location (PR_01_LC) for values.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 10 Start Date	PR_10_S_DATE	Date Other In-House Procedure 10 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Format is MM/DD/YYYY.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 10 Start Month	PR_10_S_DM	Month Other In-House Procedure 10 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 12.
Other Procedures ***(NEW SECTION)*** ***NEW ELEMENT***	F6.1	Other In-House Procedure 10 Start Day	PR_10_S_DD	Day Other In-House Procedure 10 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1 to 31.
Other Procedures ***(NEW SECTION)***	F6.1	Other In-House Procedure 10 Start Year	PR_10_S_DY	Year Other In-House Procedure 10 started. An operation includes all the procedures performed during one session of anesthesia (but excluding pre-operative anesthesia). Valid values are from 1980 to 2099.

Section	Screen	Data Element Description	Collector Data Name	Definition
NEW ELEMENT				
ICU Data	F7.1	Patient Admitted To ICU	**ICU_ADMIT**	Indicates whether the patient was admitted to the ICU. 1 = Yes 2 = No Note: (I)nappropriate or (U)nknown should not be used in this field.
ICU Data	F7.1	Patient Readmitted to ICU	**ICU_READM**	Indicates whether the patient was readmitted to the ICU. 1 = Yes 2 = No Note: (I)nappropriate or (U)nknown should not be used in this field.
ICU Data	F7.1	ICU Date of Admission	ICU1_DATE	Date that the patient was admitted to the ICU.
ICU Data	F7.1	ICU Month of Admission	ICU1_D_M	Month that the patient was admitted to the ICU. Valid values are from 1 to 12.
ICU Data	F7.1	ICU Day of Admission	ICU1_D_D	Day that the patient was admitted to the ICU. Valid values are from 1 to 31.
ICU Data	F7.1	ICU Year of Admission	ICU1_D_Y	Year that the patient was admitted to the ICU. Valid values are from 1980 to 2099.
ICU Data	F7.1	ICU Time of Admission	ICU1_TIME	Time that the patient was admitted to the ICU.
ICU Data	F7.1	ICU Hour of Admission	ICU1_T_H	Hour that the patient was admitted to the ICU. Valid values are from 0 to 23.
ICU Data	F7.1	ICU Minutes of Admission	ICU1_T_M	Minutes portion of the time that the patient was admitted to the ICU. Valid values are from 0 to 59.
ICU Data	F7.1	ICU Date of Discharge	ICU1D_DATE	Date that the patient was discharged from the ICU.
ICU Data	F7.1	ICU Month of Discharge	ICU1D_D_M	Month that the patient was discharged from the ICU. Valid values are from 1 to 12.
ICU Data	F7.1	ICU Day of Discharge	ICU1D_D_D	Day that the patient was discharged from the ICU. Valid values are from 1 to 31.
ICU Data	F7.1	ICU Year of Discharge	ICU1D_D_Y	Year that the patient was discharged from the ICU. Valid values are from 1980 to 2099.
ICU Data	F7.1	ICU Time of Discharge	ICU1D_TIME	Time that the patient was discharged from the ICU.
ICU Data	F7.1	ICU Hour of Discharge	ICU1D_T_H	Hour that the patient was discharged from the ICU. Valid values are from 0 to 23.
ICU Data	F7.1	ICU Minutes of Discharge	ICU1D_T_M	Minutes portion of the time that the patient was discharged from the ICU. Valid values are from 0 to 59.
ICU Data	F7.1	ICU Disposition	TRANSF_TO1	The destination code of the patient after discharge from the primary ICU stay. . This field is user-defined and may vary by hospital.
ICU Data	F7.1	ICU Disposition if Other	TRANSF_O1	The description of the patient's destination after discharge from the primary ICU stay, if not listed in the ICU disposition field.
ICU Data	F7.1	ICU Date of Readmission	ICU2_DATE	Date that the patient was readmitted to the ICU.
ICU Data	F7.1	ICU Month of	ICU2_D_M	Month that the patient was readmitted to the ICU. Valid values are from 1 to 12.

Section	Screen	Data Element Description	Collector Data Name	Definition
		Readmission		
ICU Data	F7.1	ICU Day of Readmission	ICU2_D_D	Day that the patient was readmitted to the ICU. Valid values are from 1 to 31.
ICU Data	F7.1	ICU Year of Readmission	ICU2_D_Y	Year that the patient was readmitted to the ICU. Valid values are from 1980 to 2099.
ICU Data	F7.1	ICU Time of Readmission	ICU2_TIME	Time that the patient was readmitted to the ICU.
ICU Data	F7.1	ICU Hour of Readmission	ICU2_T_H	Hour that the patient was readmitted to the ICU. Valid values are from 0 to 23.
ICU Data	F7.1	ICU Minutes of Readmission	ICU2_T_M	Minutes portion of the time that the patient was readmitted to the ICU. Valid values are from 0 to 59.
ICU Data	F7.1	ICU Date of Readmission Discharge	ICU2D_DATE	Date that the patient was discharged from readmission to the ICU.
ICU Data	F7.1	ICU Month of Readmission Discharge	ICU2D_D_M	Month that the patient was discharged from readmission to the ICU. Valid values are from 1 to 12.
ICU Data	F7.1	ICU Day of Readmission Discharge	ICU2D_D_D	Day that the patient was discharged from readmission to the ICU. Valid values are from 1 to 31.
ICU Data	F7.1	ICU Year of Readmission Discharge	ICU2D_D_Y	Year that the patient was discharged from readmission to the ICU. Valid values are from 1980 to 2099.
ICU Data	F7.1	ICU Time of Readmission Discharge	ICU2D_TIME	Time that the patient was discharged from readmission to the ICU.
ICU Data	F7.1	ICU Hour of Readmission Discharge	ICU2D_T_H	Hour that the patient was discharged from readmission to the ICU. Valid values are from 0 to 23.
ICU Data	F7.1	ICU Minutes of Readmission Discharge	ICU2D_T_M	Minutes portion of the time that the patient was discharged from readmission to the ICU. Valid values are from 0 to 59.
ICU Data	F7.1	ICU Readmission Disposition	TRANSF_TO2	The destination code of the patient after discharge from the readmission ICU stay. This field is user-defined and may vary by hospital
ICU Data	F7.1	ICU Readmission Disposition if Other	TRANSF_O2	The description of the patient's destination after discharge from the readmission ICU stay, if not listed in the ICU readmission disposition field
ICU Data	F7.1	Days of Primary ICU Stay	**PRIM_STAY**	Number of days the patient spent during the primary ICU stay. This field is automatically entered by Collector if the date of primary ICU admission & discharge are entered. If not, then the user must enter the number of days. This includes any critical care unit (e.g., ICU, CCU, burn unit, etc.). It does not include step-down or intermediate care units. Note: If a patient is sent to the OR or to other services with a plan to return to the ICU, then the ICU stay is counted as a single, contiguous stay. 0 = patient was not admitted to an ICU.
ICU Data	F7.1	Days of ICU Readmission Stay	**READ_STAY**	Total number of days the patient spent during readmission ICU stays. If the patient had more than one readmission to the ICU, total all these days of readmission. 0 = patient was not readmitted to an ICU.
ICU Data	F7.2	ICU Notes	NOTES_ICU	Ten lines designated for a description of patient's ICU information.

Section	Screen	Data Element Description	Collector Data Name	Definition
Outcome	F8.1	Complication 1	**COMPLIC_1**	1st of up to 10 complications which are documented in the patient's record for this stay. A complication is defined as a condition arising after admission, which occurs as a result of the patient's treatment or events during the hospitalization and requires additional medical treatment or affects the patient's length of stay. Complications must be documented in the patient record by an attending/consulting physician. Suspected exacerbation of a pre-morbid condition should not be coded as a complication unless specified by an attending/consulting physician. 00 = None 01 = Evisceration or dehiscence 02 = Arterial Occlusion 03 = Thrombosis, central venous or deep vein 04 = Pulmonary Embolism 05 = Fat Embolism 06 = Acute Respiratory Distress Syndrome (ARDS) 07 = Pneumonia 08 = Respiratory Arrest 09 = Cardiac Arrest 10 = Congestive Heart Failure (CHF) 11 = Pulmonary Edema 12 = Major Arrhythmia 13 = Myocardial Infarction (MI) 14 = Coagulopathy or Disseminated Intravascular Coagulation (DIC) 15 = Compartment Syndrome 16 = Stroke (CVA) 17 = Emphysema 18 = GI Bleed or Stress Ulcer 19 = Hemothorax or Pneumothorax 20 = Inadvertent Enterotomy 21 = Intra-abdominal Abscess 22 = Liver Failure, Hepatic Dysfunction, Jaundice or Hyperbilirubinemia 23 = Pancreatitis 24 = Pressure Sore 25 = Renal Failure or Acute Tubular Necrosis (ATN) 26 = Sepsis 27 = Shock 28 = Meningitis 29 = Urinary Track Infection (UTI) 30 = Wound Infection 31 = Hypothermia 32 = Alcohol or Drug Withdrawal 33 = Fracture, non-union 99 = Other 50-79 = Designated for user-defined complications
Outcome	F8.1	Complication 2	**COMPLIC_2**	2nd of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 3	**COMPLIC_3**	3rd of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 4	**COMPLIC_4**	4th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 5	**COMPLIC_5**	5th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 6	**COMPLIC_6**	6th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.

Section	Screen	Data Element Description	Collector Data Name	Definition
Outcome	F8.1	Complication 7	**COMPLIC_7**	7th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 8	**COMPLIC_8**	8th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 9	**COMPLIC_9**	9th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication 10	**COMPLIC_10**	10th of up to 10 complications which are documented in the patient's record for this stay. See Complication 1 (COMPLIC_1) for definition and values.
Outcome	F8.1	Complication if Other	COMPLIC_O	Text description of a complication that occurred but is not given as an option on the complication list as defined in COMPLIC_1.
ED Data	F8.1	Reintubation Required	REINTUBAT	Indicates whether the patient required reintubation within 48 hours of extubation. This includes whether extubation was by the physician, or if self-extubated by the patient. If intubation was never required, enter "I". 1 = Yes 2 = No
Outcome	F8.1	Social Work Consult	SW_CNSLT	Indicates whether a social worker consulted with a patient. This would include discharge planning or case management by a person other than a social worker. 1 = Yes 2 = No
Outcome	F8.1	Social Work Consult Date	SW_DATE	Date of the social work consultation.
Outcome	F8.1	Social Work Consult Month	SW_DATE_M	Month of the social work consultation. Valid values are from 1 to 12.
Outcome	F8.1	Social Work Consult Day	SW_DATE_D	Day of the social work consultation. Valid values are from 1 to 31.
Outcome	F8.1	Social Work Consult Year	SW_DATE_Y	Year of the social work consultation. Valid values are from 1980 to 2099.
Outcome	F8.1	Mental health Consult	MH_CNSLT	Indicates whether there was a mental health consultation with the patient (including alcohol/drug counselor, psychologist, psychiatrist,). 1 = Yes 2 = No
Outcome	F8.1	Mental health Consult Date	MH_DATE	Date of the mental health consultation.
Outcome	F8.1	Mental health Consult Month	MH_DATE_M	Month of the mental health consultation. Valid values are from 1 to 12.
Outcome	F8.1	Mental health Consult Day	MH_DATE_D	Day of the mental health consultation. Valid values are from 1 to 31.
Outcome	F8.1	Mental health Consult Year	MH_DATE_Y	Year of the mental health consultation. Valid values are from 1980 to 2099.
Outcome	F8.1	Physical therapy Consult	**PT_CNSLT**	Indicates whether there was a physical therapy consultation with the patient. 1 = Yes 2 = No
Outcome	F8.1	Physical therapy Consult Date	**PT_DATE**	Date of the physical therapy consultation.

Section	Screen	Data Element Description	Collector Data Name	Definition
Outcome	F8.1	Physical therapy Consult Month	**PT_DATE_M**	Month of the physical therapy consultation. Valid values are from 1 to 12.
Outcome	F8.1	Physical therapy Consult Day	**PT_DATE_D**	Day of the physical therapy consultation. Valid values are from 1 to 31.
Outcome	F8.1	Physical therapy Consult Year	**PT_DATE_Y**	Year of the physical therapy consultation. Valid values are from 1980 to 2099.
Outcome	F8.1	Rehabilitation Consult	**RH_CNSLT**	Indicates whether a person specializing in rehabilitation screened the patient for rehabilitation medicine. (This includes screening by the facility's Trauma Rehabilitation Coordinator). 1 = Yes 2 = No
Outcome	F8.1	Rehabilitation Consult Date	**RH_DATE**	Date of the rehabilitation consultation.
Outcome	F8.1	Rehabilitation Consult Month	**RH_DATE_M**	Month of the rehabilitation consultation. Valid values are from 1 to 12.
Outcome	F8.1	Rehabilitation Consult Day	**RH_DATE_D**	Day of the rehabilitation consultation. Valid values are from 1 to 31.
Outcome	F8.1	Rehabilitation Consult Year	**RH_DATE_Y**	Year of the rehabilitation consultation. Valid values are from 1980 to 2099.
Outcome	F8.1	Date of Discharge From Hospital or Death	**DATE_DEATH**	Indicates either the date of ***discharge*** from the hospital if the patient lived, or the date of ***death*** if the patient died. Note: Discharge includes transfers to another health care facility.
Outcome	F8.1	Month of Discharge From Hospital or Death	**D_DEATH_M**	Month of ***discharge/transfer*** from the hospital, ***transfer*** from the ED, *or* ***death***. Valid values are from 1 to 12.
Outcome	F8.1	Day of Discharge From Hospital or Death	**D_DEATH_D**	Day of ***discharge/transfer*** from the hospital, ***transfer*** from the ED, *or* ***death***. Valid values are from 1 to 31.
Outcome	F8.1	Year of Discharge From Hospital or Death	**D_DEATH_Y**	Year of ***discharge/transfer*** from the hospital, ***transfer*** from the ED, *or* ***death***. Valid values are from 1980 to 2099.
Outcome	F8.1	Time of Discharge or Death	**TIME_DEATH**	Indicates either the time of ***discharge/transfer*** from the hospital if the patient lived, the time of ***transfer*** if the patient was transferred from the ED to another hospital, ***or*** the time of ***death*** if the patient died.
Outcome	F8.1	Hour of Discharge or Death	**T_DEATH_H**	Hour of ***discharge/transfer*** from the hospital, ***transfer*** from the ED, *or* ***death***. Valid values are from 0 to 23.
Outcome	F8.1	Minutes of Discharge or Death	**T_DEATH_M**	Minutes of ***discharge/transfer*** from the hospital, ***transfer*** from the ED, *or* ***death***. Valid values are from 0 to 59.
Outcome	F8.1	Hospital Discharge Disposition	**DISCHG_TO**	Indicates where the patient went upon final discharge from the hospital. 0 = Home, no assistance 1 = Home, Health Care Assistance 2 = Home, Outpatient Rehabilitation 3 = Skilled Nursing Facility (SNF) 4 = Rehab Facility 5 = Other Acute Care Facility (i.e. transfers to another facility) 6 = Expired (Died)

Section	Screen	Data Element Description	Collector Data Name	Definition
				7 = Other, [Note: If used, a text description of where the patient went must also be entered. See (DISCG_TO_O).] 8 = Psychiatric Facility 9 = Jail, Police Custody 10 = In-house SNF (Transitional Care Unit) Note: A patient is "transferred" (choice 5) to another hospital if sent by ambulance. A patient sent by private vehicle or other means is not a "transfer" for the purposes of the Trauma Registry. For patients referred to another hospital but <u>not</u> sent by ambulance, it is recommended to enter "7 – Other" and in If Other enter "ref ID# POV". (ID# is the code of the hospital to which the patient was referred.)
Outcome	F8.1	Receiving Facility ID if Discharged From Hospital	**ACUTE_ID_N**	ID of the acute care facility where the patient went if the patient was referred to an acute care facility from the hospital. See REF_ID for defined values.
Outcome	F8.1	Hospital Discharge if Other	**DISCG_TO_O**	Text description of where the patient went upon final discharge from the hospital if not listed as an option from the Hospital Discharge Disposition Menu. Note: This field should *rarely* be used. If the patient was transferred to another acute care facility (DISCHG_TO = 5), use this field to indicate the receiving hospital ID.
Outcome	F8.1	Rehabilitation Facility ID	**REHAB_ID_N**	Indicates the ID number of the rehabilitation facility. User-defined facilities may also be added. 158 = Cascade Medical Center (Leavenworth) 014 = Children's Hospital (Seattle) 081 = Good Samaritan Hospital (Puyallup) 935 = Green Mountain Rehab Medicine (Bremerton) 029 = Harborview Medical Center (Seattle) 916 = Legacy Emanuel Hospital (Portland) 022 = Lourdes Medical Center (Pasco) 130 = Northwest Hospital (Seattle) 191 = Providence Centralia Hospital 027 = Providence Everett Medical Center 003 = Providence Medical Center (Seattle) 159 = Providence St. Peter Hospital (Olympia) 170 = Southwest Washington Medical Center (Vancouver) 026 = St. John Medical Center (Longview) 032 = St. Joseph Medical Center (Tacoma) 157 = St. Luke's Rehabilitation Center (Spokane) 050 = St. Mary Medical Center (Walla Walla) 128 = University of Washington Medical Center (Seattle) 155 = Valley Medical Center (Renton) 102 = Yakima Regional Medical Center
Outcome	F8.2	**Disability at Discharge - Feeding**	**D_DISABL_F**	Indicates the 'feeding' component of the Level of Function. Each component should be assessed as close to discharge as possible, but not earlier than 48 hours prior to discharge. 4 = Independent 3 = Independent, with Device 2 = Dependent, Partial Help 1 = Dependent, Total Help 0 = Pediatric, Age < 2
Outcome	F8.2	**Disability at Discharge – Locomotion**	**D_DISABL_L**	Indicates the 'locomotion' component of the Level of Function. Each component should be assessed as close to discharge as possible, but not earlier than 48 hours prior to discharge.

Section	Screen	Data Element Description	Collector Data Name	Definition
				4 = Independent 3 = Independent, with Device 2 = Dependent, Partial Help 1 = Dependent, Total Help 0 = Pediatric, Age < 2
Outcome	F8.2	**Disability at Discharge – Expression**	**D_DISABL_E**	Indicates the 'expression' component of the Level of Function. Each component should be assessed as close to discharge as possible, but not earlier than 48 hours prior to discharge. 4 = Independent 3 = Independent, with Device 2 = Dependent, Partial Help 1 = Dependent, Total Help 0 = Pediatric, Age < 2
Outcome	F8.2	Eye Opening Sub-Score of GCS at Discharge	**EYE_OPNG_D**	Sub-score of the Glasgow Coma Score (GCS) indicating patient *best* eye opening ***at discharge*** from the hospital. It is added to two other sub-scores to obtain the GCS at discharge. See also Discharge GCS (GCS_D). 1 = None 2 = To Pain 3 = To Voice 4 = Spontaneous U = Unknown
Outcome	F8.2	Verbal Response Sub-Score of GCS at Discharge	**VER_RESP_D**	Sub-score of the Glasgow Coma Score (GCS) indicating patient *best* verbal response ***at discharge***. It is added to two other sub-scores to obtain the GCS at discharge from the hospital. See also discharge-GCS (GCS_D). 1 = None, or intubated, or pharmacologically paralyzed 2 = Incomprehensible Sounds (Under 2 years, Agitated/Restless) 3 = Inappropriate Words (Under 2 years, Persistent Crying) 4 = Confused 5 = Oriented U = Unknown
Outcome	F8.2	Motor Response Sub-Score of GCS at Discharge	**MOT_RESP_D**	Sub-score of the Glasgow Coma Score (GCS) indicating patient's *best* motor response ***at discharge***. It is added to two other sub-scores to obtain the GCS at discharge from the hospital. See also discharge-GCS (GCS_D). 1 = None, or pharmacologically paralyzed 2 = Abnormal Extension 3 = Abnormal Flexion 4 = Withdraws to Pain 5 = Localizes Pain 6 = Obeys Commands U = Unknown
Outcome	F8.2	GCS at Discharge (Outcome GCS)	**GCS_D**	Glasgow Coma Score (GCS) is a widely used index that assesses the degree of coma in patients with craniocerebral injuries. The GCS at discharge is calculated by adding the sub-scores of three behavioral responses at discharge: best eye opening (see EYE_OPNG_D), best verbal response (see VER_RESP_D), and best motor response (see MOT_RESP_D).

Section	Screen	Data Element Description	Collector Data Name	Definition
				Values range from 3 to 15.
Outcome	F8.3	Payer Source 1	**P1_CODE**	The primary source of payment. See also Payer Source 2 (P2_CODE). 00 = None 01 = Medicare 02 = Medicaid - (Washington State Department of Social and Health Services) [DSHS] (Healthy Options) 03 = Labor and Industries (L&I) – (includes state fund, self-insured employers, and Labor and Industries crime victim's claims) 04 = Health Maintenance Organization (HMO) – (e.g. Kaiser, Group Health, Molina, Basic Health Plan) 05 = Other Insurance 08 = Self Pay 10 = Commercial Insurance – (e.g. Mutual of Omaha, Safeco) 11 = Health Care Service Contractor – (e.g. Premera Blue Cross, KPS) 12 = Other Government Sponsored Patients – (e.g. TRI-CARE, Indian Health) 13 = Charity Care
Outcome	F8.3	Payer Source 2	**P2_CODE**	The secondary source of payment. See also Payer Source 1 (P1_CODE). 00 = None 01 = Medicare 02 = Medicaid - (Washington State Department of Social and Health Services) [DSHS] (Healthy Options) 03 = Labor and Industries (L&I) – (includes state fund, self-insured employers, and Labor and Industries crime victim's claims) 04 = Health Maintenance Organization (HMO) – (e.g. Kaiser, Group Health, Molina, Basic Health Plan) 05 = Other Insurance 08 = Self Pay 10 = Commercial Insurance– (e.g. Mutual of Omaha, Safeco) 11 = Health Care Service Contractor – (e.g. Premera Blue Cross, KPS) 12 = Other Government Sponsored Patients – (e.g. TRI-CARE, Indian Health) 13 = Charity Care
Outcome	F8.3	Financial Data Available	**FINANCE_YN**	Indicates whether financial data is available at this time. 1 = Yes 2 = No
Outcome	F8.3	Total Hospital Charges	**HOSP_CHARG**	The total charges from this facility for this patient, in dollars & cents, including the decimal point.
Outcome	F8.3	Payer Source 1 Reimbursement	**P1_RETURN**	The amount received from the primary source of payment, in dollars and cents including the decimal point.
Outcome	F8.3	Payer Source 2 Reimbursement	**P2_RETURN**	The amount received from the secondary source of payment, in dollars and cents including the decimal point.
Outcome	F8.3	Total Reimbursement	**T_RETURN**	The total amount received from all sources, including the primary and secondary payers. See Payer Source 1 Reimbursement (P1_RETURN) and Payer Source 2 Reimbursement (P2_RETURN).
Outcome	F8.3	Brain-Death Prior to Death	BRAIN_DEAD	Indicates whether the patient underwent brain-death prior to death. 1 = Yes 2 = No
Outcome	F8.3	Autopsy Done	**AUTOPSY_YN**	Indicates whether an autopsy was done.

Section	Screen	Data Element Description	Collector Data Name	Definition
				1 = Yes 2 = No
Outcome	F8.3	Autopsy Results Requested	AUTOPSY_RQ	Indicates whether the autopsy results were requested. 1 = Yes 2 = No
Outcome	F8.3	Autopsy Results Received	RESULT_REC	Indicates whether the autopsy results were received when requested. 1 = Yes 2 = No
Outcome	F8.3	Organ Donation Evaluation	**ORG_REQ**	Indicates whether organ donation was requested. 1 = Yes 2 = No
Outcome	F8.3	Organ(s) Donated	**ORG_DNR**	Indicates which organs were donated. 00 = None 01 = Adrenal Glands 02 = Bone 03 = Bone Marrow 04 = Cartilage 05 = Cornea 06 = Dura Mater 07 = Fascialata 08 = Heart 09 = Heart & Lungs 10 = Heart & Valves 11 = Kidneys 12 = Liver 13 = Lungs 14 = Nerves 15 = Pancreas 16 = Skin 17 = Tendons 18 = Multiple Organ Donation 19 = All
Outcome ***NEW ELEMENT***	F8.3	Life Support Withdrawn	LIFE_SPT	Indicates whether life support was withdrawn. 1 = Yes 2 = No
Outcome	F8.3	Cause of Death	C_DEATH	Ten lines designated for a description of patient's cause of death.
Outcome	F8.4	Discharge Memo	NOTES_DSCH	Ten lines designated for a description of patient's discharge.
Outcome	F8.8	QA Comments	QA_COMM	Ten lines designated for a description of patient's injury QA comments.
Diagnoses	F9.1	Injury Severity Score (ISS)	**ISS**	Note: This field is calculated by Collector. The Injury Severity Score (ISS) is a summary score for traumatic injuries. The ISS is calculated as the square of the AIS. If a patient has more than one AIS, the highest AIS value is selected from each of up to six body regions (head/neck, face, thorax, abdominal and pelvic contents, limbs, and skin), and the three highest of these are squared and summed. If any AIS score is 6, then the ISS is set at 75. Values range from 1 (best) to 75 (almost always fatal).

Section	Screen	Data Element Description	Collector Data Name	Definition
				ISS = 75 if patient has severity value of 6 (nearly always fatal), Otherwise, ISS = (1^{st} of 3 highest AIS)^2 + (2^{nd} of 3 highest AIS)^2 + (3^{rd} of 3 highest AIS)^2
Diagnoses	F9.1	Received Injury Severity Score (Received ISS)	**RECV_ISS**	The Received Injury Severity Score is the ISS that was calculated at the referring hospital if the patient is transferred in from another hospital. See ISS for a complete definition of Injury Severity Score.
Diagnoses	F9.1	TRISS	**TRISS**	TRISS is a method used to estimate probability of survival (P_s) as a function of injury severity (ISS), revised trauma score (RTS), patient age, and type of injury (blunt or penetrating), using a logistic model: $P_s = 1 / (1 + e^{-b})$, where e = 2.7183 and $b = b_0 + b_1$ (RTS) + b_2 (ISS) + b_3 (AGE) where b_0, b_1, b_2, and b_3 are weights derived from study data; RTS is the Revised Trauma Score on Admission; ISS is the Injury Severity Score; and AGE = 1 if patient age is over 54 years, and AGE = 0 if patient age is 54 years or less. The TRISS regression weights for AIS-90 based norms are defined below[1]: b_0 b_1 (RTS) b_2(ISS) b_3(AGE*) Blunt -.4499 0.8085 -0.0835 -1.7430 Penetrating -2.5355 0.9934 -0.0651 -1.1360 The adult blunt-injured coefficients (AGE=0) are also for both blunt and penetrating-injured pediatric patients (<15 years old). See also RTS_A, ISS, and BLUNT_PENT. Note: TRISS will be calculated only if all components have values. 1. Champion, Sacco, Copes: Injury Severity Scoring Again. *J Trauma* 38:94, 1995.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Version	AIS_VER	Indicates the AIS version being used for the AIS - ICD-9-CM mapping. See AIS_01.
Diagnoses	F9.2	ICD-9-CM Code 1	**ICD9_01**	1^{st} ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 1	**AIS_01**	The Abbreviated Injury Scale (AIS) & Body Region value 1 for this patient. The AIS is a list of several hundred injuries, each assigned a severity value of 1 (minor) to 6 (nearly always fatal) and a body region from 1 to 6. The AIS severity values have been "assigned" to ICD-9-CM injury rubrics so that ICD-9-CM injury codes listed in hospital discharge summaries can be mapped to AIS values. These values can then be used in the computation of Injury Severity Score (ISS). See also AIS_VER. **1^{st} digit = AIS Severity** 0 = None 1 = Minor 2 = moderate 3 = serious 4 = Severe 5 = Critical 6 = Maximum (Nearly Always Fatal) 9 = Unknown (Cannot Be Used In Scoring) **2^{nd} digit = AIS Body Region** 1 = head/neck 2 = face 3 = thorax

Section	Screen	Data Element Description	Collector Data Name	Definition
				4 = abdomen and pelvic contents 5 = extremities 6 = external (skin) 9 = Inappropriate
Diagnoses	F9.2	PREDOT Code 1	**PREDOT_01**	1st of up to 27 Predot codes. The predot code corresponds to the 6 digits preceding the decimal point in the pre-defined associated AIS *Code*. (The Abbreviated Injury *Score* is the digit to the right of the decimal point. See AIS_01). The predot code is generated when using the TRICODE option in Collector, which assigns ICD-9-CM, AIS, and Body Regions from text injury descriptions. The following conventions are used in assigning the numerics to specific injury codes: **1st digit = Body Region** 1 = head 2 = face 3 = neck 4 = thorax 5 = abdomen 6 = spine 7 = upper extremity 8 = lower extremity 9 = unspecified (including burns/skin) **2nd digit = Type of Anatomic Structure** 1 = whole area 2 = vessels 3 = nerves 4 = organs (including muscles/ligaments) 5 = skeletal (including joints) 6 = head - LOS (loss of consciousness) **3rd & 4th digits = Specific Anatomic Structure or Nature** **Whole Area** 02 = skin - abrasion 04 = skin - contusion 06 = skin - laceration 08 = skin - avulsion 10 = amputation 20 = burn 30 = crush 40 = degloving 50 = injury - NFS 60 = penetrating 90 = trauma, other than mechanical **Head - LOC** 02 = length of LOC 04 = level of consciousness 06 = level of consciousness 08 = level of consciousness 10 = concussion **Spine** 02 = cervical 04 = thoracic 06 = lumbar **Vessels, Nerves, Organs, Bones, Joints** Are assigned consecutive two digit numbers beginning with 02 **5th & 6th digits = LEVEL** Specific injuries are assigned consecutive two-digit numbers beginning with 02

Section	Screen	Data Element Description	Collector Data Name	Definition
Diagnoses	F9.2	ICD-9-CM Code 2	**ICD9_02**	2nd ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 2	**AIS_02**	The Abbreviated Injury Scale (AIS) value 2 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 2	**PREDOT_02**	2nd predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 3	**ICD9_03**	3rd ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 3	**AIS_03**	The Abbreviated Injury Scale (AIS) value 3 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 3	**PREDOT_03**	3rd predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 4	**ICD9_04**	4th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 4	**AIS_04**	The Abbreviated Injury Scale (AIS) value 4 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 4	**PREDOT_04**	4th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 5	**ICD9_05**	5th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 5	**AIS_05**	The Abbreviated Injury Scale (AIS) value 5 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 5	**PREDOT_05**	5th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 6	**ICD9_06**	6th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 6	**AIS_06**	The Abbreviated Injury Scale (AIS) value 6 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 6	**PREDOT_06**	6th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 7	**ICD9_07**	7th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 7	**AIS_07**	The Abbreviated Injury Scale (AIS) value 7 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 7	**PREDOT_07**	7th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 8	**ICD9_08**	8th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 8	**AIS_08**	The Abbreviated Injury Scale (AIS) value 8 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 8	**PREDOT_08**	8th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 9	**ICD9_09**	9th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 9	**AIS_09**	The Abbreviated Injury Scale (AIS) value 9 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 9	**PREDOT_09**	9th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 10	**ICD9_10**	10th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated	**AIS_10**	The Abbreviated Injury Scale (AIS) value 10 for this patient. See AIS_01 for a

Section	Screen	Data Element Description	Collector Data Name	Definition
		Injury Scale (AIS) Value 10		complete definition and for values.
Diagnoses	F9.2	PREDOT Code 10	**PREDOT_10**	10th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 11	**ICD9_11**	11th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 11	**AIS_11**	The Abbreviated Injury Scale (AIS) value 11 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 11	**PREDOT_11**	11th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 12	**ICD9_12**	12th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 12	**AIS_12**	The Abbreviated Injury Scale (AIS) value 12 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 12	**PREDOT_12**	12th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 13	**ICD9_13**	13th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 13	**AIS_13**	The Abbreviated Injury Scale (AIS) value 13 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 13	**PREDOT_13**	13th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 14	**ICD9_14**	14th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 14	**AIS_14**	The Abbreviated Injury Scale (AIS) value 14 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 14	**PREDOT_14**	14th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 15	**ICD9_15**	15th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 15	**AIS_15**	The Abbreviated Injury Scale (AIS) value 15 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 15	**PREDOT_15**	15th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 16	**ICD9_16**	16th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 16	**AIS_16**	The Abbreviated Injury Scale (AIS) value 16 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 16	**PREDOT_16**	16th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 17	**ICD9_17**	17th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 17	**AIS_17**	The Abbreviated Injury Scale (AIS) value 17 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 17	**PREDOT_17**	17th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 18	**ICD9_18**	18th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 18	**AIS_18**	The Abbreviated Injury Scale (AIS) value 18 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code	**PREDOT_18**	18th predot code. See PREDOT 1 for a complete definition.

Section	Screen	Data Element Description	Collector Data Name	Definition
		18		
Diagnoses	F9.2	ICD-9-CM Code 19	**ICD9_19**	19th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 19	**AIS_19**	The Abbreviated Injury Scale (AIS) value 19 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 19	**PREDOT_19**	19th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 20	**ICD9_20**	20th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 20	**AIS_20**	The Abbreviated Injury Scale (AIS) value 20 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 20	**PREDOT_20**	20th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 21	**ICD9_21**	21st ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 21	**AIS_21**	The Abbreviated Injury Scale (AIS) value 21 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 21	**PREDOT_21**	21st predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 22	**ICD9_22**	22nd ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 22	**AIS_22**	The Abbreviated Injury Scale (AIS) value 22 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 22	**PREDOT_22**	22nd predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 23	**ICD9_23**	23rd ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 23	**AIS_23**	The Abbreviated Injury Scale (AIS) value 23 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 23	**PREDOT_23**	23rd predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 24	**ICD9_24**	24th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 24	**AIS_24**	The Abbreviated Injury Scale (AIS) value 24 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 24	**PREDOT_24**	24th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 25	**ICD9_25**	25th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 25	**AIS_25**	The Abbreviated Injury Scale (AIS) value 25 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 25	**PREDOT_25**	25th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 26	**ICD9_26**	26th ICD-9-CM injury code for this patient.
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 26	**AIS_26**	The Abbreviated Injury Scale (AIS) value 26 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 26	**PREDOT_26**	26th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.2	ICD-9-CM Code 27	**ICD9_27**	27th ICD-9-CM injury code for this patient.

Section	Screen	Data Element Description	Collector Data Name	Definition
Diagnoses	F9.2	Abbreviated Injury Scale (AIS) Value 27	**AIS_27**	The Abbreviated Injury Scale (AIS) value 27 for this patient. See AIS_01 for a complete definition and for values.
Diagnoses	F9.2	PREDOT Code 27	**PREDOT_27**	27th predot code. See PREDOT 1 for a complete definition.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 1	NT_ICD9_01	1st of up to 10 non-trauma ICD-9-CM Codes. These codes allow analysts to account for co-existing medical conditions, using ICD-9-CM codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 2	NT_ICD9_02	2nd of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 3	NT_ICD9_03	3rd of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 4	NT_ICD9_04	4th of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 5	NT_ICD9_05	5th of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 6	NT_ICD9_06	6th of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 7	NT_ICD9_07	7th of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 8	NT_ICD9_08	8th of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 9	NT_ICD9_09	9th of up to 10 non-trauma ICD-9-CM Codes.
Diagnoses	F9.3	Non-Trauma ICD-9-CM Code 10	NT_ICD9_10	10th of up to 10 non-trauma ICD-9-CM Codes.
Reserved Data	F10.1	Washington State Reserved Element 10	**HOSP01**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 11	**HOSP02**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 12	**HOSP03**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 13	**HOSP04**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 14	**HOSP05**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 15	**HOSP06**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 16	**HOSP07**	User-defined field. It is currently undefined.
Reserved Data	F10.1	Washington State Reserved Element 17	**HOSP08**	User-defined field. It is currently undefined.
Reserved	F10.1	Washington	**HOSP09**	User-defined field. It is currently undefined.

Section	Screen	Data Element Description	Collector Data Name	Definition
Data		State Reserved Element 18		
Reserved Data	F10.1	Washington State Reserved Element 19	**HOSP10**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 1	**HOSP11**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 2	**HOSP12**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 3	**HOSP13**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 4	**HOSP14**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 5	**HOSP15**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 6	**HOSP16**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 7	**HOSP17**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 8	**HOSP18**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 9	**HOSP19**	User-defined field. It is currently undefined.
Reserved Data	F10.2	Washington State Reserved Element 20	**HOSP20**	User-defined field. It is currently undefined.

				Note: Data below does not appear in Collector data-entry screens, but is available for report-writing.
Scores	N/A	A-Score Component of Anatomic Profile	A_SCORE	Indicates the "A" component of the Anatomic Profile (AP), a score that was developed to compare groups of patients with similar injuries and is comprised of four scores (A, B, C, D). The first three components summarize all serious (AIS > 2) injuries to (A) the head/brain and spinal cord**,** (B) the thorax and front of the neck, and (C) all remaining serious injuries, and are used in the calculation of ASCOT. (D) is a summary measure of all non-serious injuries & is not used in the calculation. AP component "A" is computed by taking the square root of the sum of squares of AIS scores for injury in AP component A. For example, a patient with two AIS 5 injuries and one AIS 3 injury in AP component A (injuries to the head/brain and spinal cord) has an A score of 7.68 [$\sqrt{(5^2 + 5^2 + 3^2)}$]. If no serious injuries to the head/brain and spinal cord were sustained, A = 0.
Scores	N/A	ASCOT (A Severity Characterizatio n of Trauma) Probability of Survival	ASCOT	ASCOT combines emergency department admission values (***as coded for RTS***) of the Glasgow Coma Scale (G), systolic blood pressure (S), and respiratory rate (R) with 3 AP components and patient age[1]. ASCOT $P_s = 1/(1 + e^{-k})$ Where $k = k_0 + k_1G + k_2S + k_3R + k_4A + k_5B + k_6C + k_7AGE$ and G = coded value of ED Glasgow Coma Scale (see G_SCORE_A), S = coded value of ED systolic blood pressure (see S_SCORE_A), R = coded value of ED respiratory rate (see R_SCORE_A), A = Anatomic Profile (AP) "A" component (see A_SCORE), B = Anatomic Profile (AP) "B" component (see B_SCORE), C = Anatomic Profile (AP) "C" component (see C_SCORE). (Note: The D component of AP was not significant in predicting P_s) AGE Ages (years) 0 0 - 54 1 55 - 64 2 65 - 74 3 75 - 84 4 >=85 ASCOT Model Weights Blunt Penetrating k_0 -1.1570 -1.1350 k_1 0.7705 1.0626 k_2 0.6583 0.3638 k_3 0.2810 0.3332 k_4 -0.3002 -0.3702 k_5 -0.1961 -0.2053 k_6 -0.2086 -0.3188 k_7 -0.6355 -0.8365 1. Trauma, 3rd Edition, Moore, Mattox, Feliciano, 1996, pp. 61-62.
Scores	N/A	B-Score Component of Anatomic Profile	B_SCORE	Indicates the "B" component of the Anatomic Profile (AP), a score that was developed to compare groups of patients with similar injuries and is comprised of four scores (A, B, C, D). The first three components summarize all serious (AIS > 2) injuries to (A) the head/brain and spinal cord**, (B) the thorax and front of the neck,** and (C) all remaining serious injuries, and are used in the calculation of ASCOT. (D) is a summary measure of all non-serious injuries & is not used in the calculation AP component "B" is computed by taking the square root of the sum of squares of AIS scores for injury in AP component A. For example, a patient with two

				AIS 5 injuries and one AIS 3 injury in AP component B (injuries to the thorax and front of the neck) has a B score of 7.68 [$\sqrt{(5^2 + 5^2 + 3^2)}$]. If no injuries to the thorax and front of the neck were sustained, B = 0.
Scores	N/A	C-Score Component of Anatomic Profile	C_SCORE	Indicates the "C" component of the Anatomic Profile (AP), a score that was developed to compare groups of patients with similar injuries and is comprised of four scores (A, B, C, D). The first three components summarize all serious (AIS > 2) injuries to (A) the head/brain and spinal cord**,** (B) the thorax and front of the neck**,** and **(C) all remaining serious injuries**, and are used in the calculation of ASCOT. (D) is a summary measure of all non-serious injuries & is not used in the calculation AP component "C" is computed by taking the square root of the sum of squares of AIS scores for injury in AP component C. For example, a patient with two AIS 5 injuries and one AIS 3 injury in AP component C (all remaining injuries) has a C score of 7.68 [$\sqrt{(5^2 + 5^2 + 3^2)}$]. If no remaining serious injuries were sustained, C = 0.
Scores	N/A	D-Score Component of Anatomic Profile	D_SCORE	Indicates the "D" component of the Anatomic Profile (AP), a score that was developed to compare groups of patients with similar injuries and is comprised of four scores (A, B, C, D). The first three components summarize all serious (AIS > 2) injuries to (A) the head/brain and spinal cord**,** (B) the thorax and front of the neck, and (C) all remaining serious injuries, and are used in the calculation of ASCOT. **(D) is a summary measure of all non-serious injuries and is not used in the calculation of ASCOT.** AP component "D" is computed by taking the square root of the sum of squares of AIS scores for injury in AP component D - all non-serious injuries.
Outcome	N/A	Discharge Status	DIS_STATUS	Indicates whether the patient lived, died, or whether the information is missing. 6 = lived 7 = died U = unknown
Scores	N/A	MTOS Etiology	ETIOLOGY	Etiology categorization of cause of injury for the Major Trauma Outcome Study (MTOS) using defined E-Code ranges and the variables E_CODE and E_CODE2. 1 = Motor Vehicle Accident 2 = Motorcycle Accident 3 = Pedestrian Accident 4 = Gunshot Wound 5 = Stabbing 6 = Fall 7 = Other
Scores ***NEW DERIVED***	N/A	MTOS Primary Etiology	ET_MTOS1	Primary etiology categorization of cause of injury for the Major Trauma Outcome Study (MTOS) using defined E-Code ranges and the variables E_CODE and E_CODE2. 1 = Motor Vehicle Accident 2 = Motorcycle Accident 3 = Pedestrian Accident 4 = Gunshot Wound 5 = Stabbing 6 = Fall 7 = Other
Scores ***NEW DERIVED***	N/A	MTOS Primary Etiology – Other	ET_MTOSO1	Primary other etiology categorization of cause of injury for the Major Trauma Outcome Study (MTOS) using defined E-Code ranges and the variables E_CODE and E_CODE2.

				1 = Motor Vehicle Accident 2 = Motorcycle Accident 3 = Pedestrian Accident 4 = Gunshot Wound 5 = Stabbing 6 = Fall 70 = Hot/Corrosive Material Injury 71 = Pedal Cycle Accident 72 = Air/Water Craft 73 = Fire/Flame 74 = Struck By/Against and Object/Person 75 = Caught Between Objects 76 = Machinery/Powered Tools 77 = Fight/Assault/Abuse 78 = Animal Related 79 = Other
Scores ***NEW DERIVED***	N/A	MTOS Secondary Etiology	ET_MTOS2	Secondary etiology categorization of cause of injury for the Major Trauma Outcome Study (MTOS) using defined E-Code ranges and the variables E_CODE and E_CODE2. See MTOS Primary Etiology (ET_MTOS1) for values.
Scores ***NEW DERIVED***	N/A	MTOS Secondary Etiology – Other	ET_MTOSO2	Secondary other etiology categorization of cause of injury for the Major Trauma Outcome Study (MTOS) using defined E-Code ranges and the variables E_CODE and E_CODE2. See MTOS Primary Etiology - Other (ET_MTOSO1) for values.
Scores ***NEW DERIVED***	N/A	ACE Primary Etiology	ET_ECAT1	Primary etiology categorization of cause of injury for Alternate Classification of E-Code (ACE) using defined E-Code ranges and the variables E_CODE and E_CODE2. 11 = MV Traffic 12 = Motorcycle 13 = Pedestrian 14 = Pedal cyclist 15 = Other Transport 16 = Falls 17 = Fire/Burn 18 = Inhalation 19 = Machinery 20 = Natural/Environmental 21 = Overexertion 22 = Poisoning 23 = Submersion/Suffocation/Foreign Bodies 24 = Struck By/Against 25 = GSW 26 = Stabbing 27 = Other Suicides 28 = Other Assault 29 = Other Cause – Specified 30 = Other Cause – Unspecified
Scores ***NEW DERIVED***	N/A	ACE Primary Etiology – Detailed	ET_ECATD1	Primary detailed etiology categorization of cause of injury for Alternate Classification of E-Code (ACE) using defined E-Code ranges and the variables E_CODE and E_CODE2. 1110 = MV Traffic – Unintentional 1120 = MV Traffic – Intentional, Self-Inflicted 1130 = MV Traffic – Undetermined Intent 1210 = Motorcycle – MV Traffic 1220 = Motorcycle – Other 1310 = Pedestrian – MV Traffic 1320 = Pedestrian – Other

				1410 = Pedal cyclist – MV Traffic 1420 = Pedal cyclist – Other 1510 = Other Transport – Railway 1520 = Other Transport – Water Transport 1531 = Other Transport – Air and Space – Unintentional 1532 = Other Transport – Air and Space – Intentional, Self-Inflicted 1533 = Other Transport – Air and Space – Undetermined Intent 1541 = Other Transport – Other – Unintentional 1542 = Other Transport – Other – Intentional 1610 = Falls – Unintentional 1620 = Falls – Intentional, Assault 1630 = Falls – Intentional, Self-Inflicted 1640 = Falls – Undetermined Intent 1711 = Fire/Burn – Fire/Flame – Unintentional 1712 = Fire/Burn – Fire/Flame – Intentional, Assault 1713 = Fire/Burn – Fire/Flame – Intentional, Self-Inflicted 1714 = Fire/Burn – Fire/Flame – Undetermined Intent 1721 = Fire/Burn – Hot Object/Substance – Unintentional 1722 = Fire/Burn – Hot Object/Substance – Intentional, Assault 1723 = Fire/Burn – Hot Object/Substance – Intentional, Self-Inflicted 1724 = Fire/Burn – Hot Object/Substance – Undetermined Intent 1731 = Fire/Burn – Electric Current – Unintentional 1732 = Fire/Burn – Electric Current – Intentional, Self-Inflicted 1733 = Fire/Burn – Electric Current – Undetermined Intent 1810 = Inhalation – Unintentional 1820 = Inhalation – Intentional, Self-Inflicted 1900 = Machinery 2010 = Natural/Environmental – Unintentional 2020 = Natural/Environmental – Intentional, Self-Inflicted 2030 = Natural/Environmental – Undetermined Intent 2040 = Natural/Environmental – Bites and Stings 2100 = Overexertion 2211 = Poisoning – Drugs/Medicinal/Biological – Unintentional 2212 = Poisoning – Drugs/Medicinal/Biological – Intentional, Assault 2213 = Poisoning – Drugs/Medicinal/Biological – Intentional, Self-Inflicted 2214 = Poisoning – Drugs/Medicinal/Biological – Undetermined Intent 2221 = Poisoning – Not Drug Related – Unintentional 2222 = Poisoning – Not Drug Related – Intentional, Assault 2223 = Poisoning – Not Drug Related – Intentional, Self-Inflicted 2224 = Poisoning – Not Drug Related – Undetermined Intent 2225 = Poisoning – Not Drug Related – Legal Intervention 2310 = Submersion/Suffocation/Foreign Bodies – Unintentional 2320 = Submersion/Suffocation/Foreign Bodies – Intentional, Assault 2330 = Submersion/Suffocation/Foreign Bodies – Intentional, Self-Inflicted 2340 = Submersion/Suffocation/Foreign Bodies – Undetermined Intent 2410 = Struck By/Against – Falling Object 2420 = Struck By/Against – In Sports 2431 = Struck By/Against – Other – Unintentional 2432 = Struck By/Against – Other – Intentional 2433 = Struck By/Against – Other – Legal Intervention 2510 = GSW – Unintentional 2520 = GSW – Intentional, Assault 2530 = GSW – Intentional, Self-Inflicted 2540 = GSW – Undetermined Intent 2550 = GSW – Legal Intervention 2610 = Stabbing – Unintentional 2620 = Stabbing – Intentional, Assault 2630 = Stabbing – Intentional, Self-Inflicted 2640 = Stabbing – Undetermined Intent 2650 = Stabbing – Legal Intervention 2700 = Other Suicides 2800 = Other Assaults 2900 = Other Cause – Specified

				3000 = Other Cause - Unspecified
Scores ***NEW DERIVED***	N/A	ACE Secondary Etiology	ET_ECAT2	Secondary etiology categorization of cause of injury for Alternate Classification of E-Code (ACE) using defined E-Code ranges and the variables E_CODE and E_CODE2. See ACE Primary Etiology (ET_ECAT1) for values.
Scores ***NEW DERIVED***	N/A	ACE Secondary Etiology – Detailed	ET_ECATD2	Secondary detailed etiology categorization of cause of injury for Alternate Classification of E-Code (ACE) using defined E-Code ranges and the variables E_CODE and E_CODE2. See ACE Primary Etiology – Detailed (ET_ECATD1) for values.
Scores ***NEW DERIVED***	N/A	Primary Etiology by E-Code Groups	ET_EC1	Primary etiology by E-Code Groups categorization using defined E-Code ranges and the variables E_CODE and E_CODE2. 1 = Railway Accidents 2 = Motor Vehicle Traffic 3 = Motor Vehicle Nontraffic 4 = Other Road Vehicle 5 = Pedal Cycles 6 = Water Transport 7 = Air & Space Transport 8 = Vehicle Accidents NEC 9 = Falls 10 = Fire and Flames 11 = Hot Substance or Object 12 = Drowning and Suffocation 13 = Homicide & Assault 14 = Suicide & Self-Inflicted 15 = Undetermined if Accidental or SI 16 = Cutting or Piercing 17 = Firearm Missile 18 = Natural & Environmental Factors 19 = Foreign Bodies 20 = Struck by Object or Persons in Sports 21 = Caused by Machinery 22 = Legal Interventions 23 = Operations of War 24 = Other Accidents 25 = Terrorism 99 = Other
Scores ***NEW DERIVED***	N/A	Primary Etiology by E-Code Groups – Detailed	ET_ECD1	Primary detailed etiology by E-Code Groups categorization using defined E-Code ranges and the variables E_CODE and E_CODE2. 10 = Railway Accidents 20 = Motor Vehicle Traffic 30 = Motor Vehicle Nontraffic 40 = Other Road Vehicle 50 = Pedal Cycles 60 = Water Transport 70 = Air & Space Transport 80 = Vehicle Accidents NEC 91 = Falls – Playground 92 = Falls – Sports 93 = Falls – Other 100 = Fire and Flames 110 = Hot Substance or Object 120 = Drowning and Suffocation 130 = Homicide & Assault 140 = Suicide & Self-Inflicted 150 = Undetermined if Accidental or SI 160 = Cutting or Piercing 170 = Firearm Missile 180 = Natural & Environmental Factors

				190 = Foreign Bodies 200 = Struck by Object or Persons in Sports 211 = Caused by Machinery – Agriculture 212 = Caused by Machinery - Other 220 = Legal Interventions 230 = Operations of War 241 = Other Accidents – Falling Objects 242 = Other Accidents – By Object or Person 243 = Other Accidents – Caught In or Between 244 = Other Accidents – Explosion of Pressure Vehicle 245 = Other Accidents – Explosive Material 246 = Other Accidents – Electric Current 247 = Other Accidents – Radiation/Exposure 248 = Other Accidents – Over-exertion 249 = Other Accidents – Other/Unspecified Accident 250 = Terrorism 990 = Other
Scores ***NEW DERIVED***	N/A	Secondary Etiology by E-Code Groups	ET_EC2	Secondary etiology by E-Code Groups categorization using defined E-Code ranges and the variables E_CODE and E_CODE2. See Primary Etiology by E-Code Groups (ET_EC1) for values.
Scores ***NEW DERIVED***	N/A	Secondary Etiology by E-Code Groups - Detailed	ET_ECD2	Secondary detailed etiology by E-Code Groups categorization using defined E-Code ranges and the variables E_CODE and E_CODE2. See Primary Etiology by E-Code Groups – Detailed (ET_ECD1) for values.
Scores	N/A	Functional Independence Measure (FIM)	FIM	The Functional Independence Measure (FIM) was developed to characterize patient disability resulting from trauma or non-trauma causes. Three FIM components are chosen to provide a useful summary measure of patient disability at discharge from acute care: self feeding, expression, and locomotion. The sum of the three components determines the FIM Score. See also D_DISABL_F, D_DISABL_E, and D_DISABL_L.
Scores	N/A	ASCOT Component G	G_SCORE_A	Indicates the value of emergency department GCS, ***coded for RTS***. It is used in the computation of ASCOT. See also RTS_A.
Scores	N/A	Highest Overall Abbreviated Injury Score (AIS)	MAXIMUM_AIS	Indicates the highest AIS score for all six body regions. MAXIMUM_AIS is used in the calculation of ISS. Values range from 1(minor) to 6 (nearly always fatal). If the highest overall AIS score is a 6, the ISS is automatically assigned a maximum value of 75. See also AIS_01, MAXIMUM_AIS_1, and ISS.
Scores	N/A	Highest Abbreviated Injury Score (AIS) For Body Region 1	MAXIMUM_AIS_1	The highest AIS score for body region 1: head/neck. The highest AIS scores for all six defined body regions are used in the calculation of Injury Severity Score (ISS). Values range from 1(minor) to 6(nearly always fatal) and are based upon which AIS Version is being used. See also AIS_VERSION, AIS_01, and ISS.
Scores	N/A	Highest Abbreviated Injury Score (AIS) For Body Region 2	MAXIMUM_AIS_2	The highest AIS score for body region 2: face. See MAXIMUM_AIS_1 for a complete definition and values.
Scores	N/A	Highest Abbreviated Injury Score (AIS) For Body Region 3	MAXIMUM_AIS_3	The highest AIS score for body region 3: thorax. See MAXIMUM_AIS_1 for a complete definition and values.
Scores	N/A	Highest Abbreviated Injury Score (AIS) For Body Region 4	MAXIMUM_AIS_4	The highest AIS score for body region 4: abdominal or pelvic contents. See MAXIMUM_AIS_1 for a complete definition and values.

Scores	N/A	Highest Abbreviated Injury Score (AIS) For Body Region 5	MAXIMUM_AIS_5	The highest AIS score for body region 5: extremities or pelvic girdle. See MAXIMUM_AIS_1 for a complete definition and values.
Scores	N/A	Highest Abbreviated Injury Score (AIS) For Body Region 6	MAXIMUM_AIS_6	The highest AIS score for body region 6: external structures. See MAXIMUM_AIS_1 for a complete definition and values.
Scores	N/A	ASCOT Component R	R_SCORE_A	Indicates the value of emergency department respiratory rate, ***coded for RTS***. It is used in the computation of ASCOT. See also ASCOT.
Scores	N/A	ASCOT Component S	S_SCORE_A	Indicates the value of emergency department systolic blood pressure, ***coded for RTS***. It is used in the computation of ASCOT. See also ASCOT.
Pre-H/Transfer	N/A	Scene Time in Minutes	SCENE_TIME	The elapsed time (in minutes) between arrival of the 1st unit at the scene and departure of the patient from the scene. Valid values are from 000 to 999.
ED Data	N/A	Temperature in Centigrade	TEMP_C	*Calculated* temperature in *Centigrade* if the recorded temperature (TEMP_E) is entered in Fahrenheit.
ED Data	N/A	Temperature in Fahrenheit	TEMP_F	*Calculated* temperature in *Fahrenheit* if the recorded temperature (TEMP_E) is entered in Centigrade.
ED Data ***NEW DERIVED***	NA	ED Length of Stay (Hours)	ED_HOURS	A Collector computed data element defined as the elapsed time (in hours) from ED Arrival to ED Discharge.
ED Data ***NEW DERIVED***	NA	ED Length of Stay (Minutes)	ED_MINUTES	A Collector computed data element defined as the elapsed time (in minutes) from ED Arrival to ED Discharge.
Outcomes ***NEW DERIVED***	NA	Hospital Days	HOSP_DAYS	A Collector computed data element defined as the number of days spent in the hospital beginning with ED Arrival and ending with Hospital Discharge. The day of arrival is counted as a Hospital Day; the day of discharge is not. DOA's are assigned 0 Hospital Days. • Examples: 1) A patient that arrived on 01/01/2004 and was discharged on 01/01/2004 will have 1 hospital day. 2) A patient that arrived on 01/01/2004 and was discharged on 01/03/2004 will have 2 hospital days.
Outcomes ***NEW DERIVED***	NA	In-Patient Hospital Days	ED_INPATIENT_DAYS	A Collector computed data element defined as the number of days spent in the hospital beginning with ED Arrival and ending with Hospital Discharge. The calculation is similar to Hospital Days, except In-patient Hospital Days are 0 for all patients that die in (including DOA's) or are discharged from the ED.
Outcomes ***NEW DERIVED***	NA	In-Patient Days	INPATIENT_DAYS	A Collector computed data element defined as the number of days spent in the hospital beginning with ED Discharge and ending with Hospital Discharge. All patients that die in (including DOA's) or are discharged from the ED are assigned 0 In-patient Days.
Outcomes ***NEW DERIVED***	NA	Hospital Length of Stay (Hours)	HOSP_HOURS	A Collector computed data element defined as the number of hours from ED Arrival to Hospital Discharge. Both dates and times are needed for this calculation.
Outcomes ***NEW DERIVED***	NA	Hospital Length of Stay (Minutes)	HOSP_MINUTES	A Collector computed data element defined as the number of minutes from ED Arrival to Hospital Discharge. Both dates and times are needed for this calculation.
Outcomes	NA	In-Patient	INPATIENT_H	A Collector computed data element defined as the number of hours from ED

NEW DERIVED		Length of Stay (Hours)	OURS	Discharge to Hospital Discharge. Both dates and times are needed for this calculation.
Outcomes ***NEW DERIVED***	NA	In-Patient Length of Stay (Minutes)	INPATIENT_MINUTES	A Collector computed data element defined as the number of minutes from ED Discharge to Hospital Discharge. Both dates and times are needed for this calculation.

Appendix

E849.x
Place of Occurrence details

The E849.x series is for use to denote the place where an injury or poisoning occurred.

E849.0 HOME
- Apartment
- Boardinghouse
- Farmhouse
- Home premises
- House (residential)
- Noninstitutional place of residence
- Private
  - Driveway
  - Garage
  - Garden
  - Home
  - Walk
- Swimming Pool in private house or garden
- Yard of Home
- ***Excludes***
  - home under construction but not yet occupied (E849.3)
  - institutional place of residence (E849.7)

E849.1 FARM
- Buildings
- Land under cultivation
- ***Excludes*** farmhouse and home premises of farm (E849.0)

E849.2 MINE and QUARRY
- Gravel pit
- Sand pit
- Tunnel under construction

E849.3 INDUSTRIAL PLACE AND PREMISES
- Building under construction
- Dockyard
- Dry dock
- Factory
  - Building
  - Premises
- Garage (place of work)
- Industrial yard
- Loading platform (factory) (store)
- Plant, Industrial
- Railway yard
- Shop (place of work)
- Warehouse
- Workhouse

E849.4 PLACE FOR RECREATION AND SPORT
- Amusement park
- Baseball field
- Basketball court
- Beach resort
- Cricket ground
- Fives court
- Football field
- Golf course
- Gymnasium
- Hockey field
- Holiday camp
- Ice palace
- Lake resort
- Mountain resort
- Playground, including school playground
- Public park
- Racecourse
- Resort, Not Otherwise Specified
- Riding school
- Rifle range
- Seashore resort
- Skating rink
- Sports ground
- Sports palace
- Stadium
- Swimming pool, public
- Tennis court
- Vacation resort

Excludes that in private house or garden (E849.0)

E849.5 STREET AND HIGHWAY
E849.6 PUBLIC BUILDING: Building (including adjacent grounds) used by the general public or by a particular group of the public, such as:
- Airport
- Bank
- Café
- Casino
- Church
- Cinema
- Clubhouse
- Courthouse
- Dance hall
- Garage building (for car storage)
- Hotel
- Market (grocery or other commodity)
- Movie house
- Music hall
- Nightclub
- Office
- Office building
- Opera house
- Post office
- Public hall
- Radio broadcasting station
- Restaurant
- School (state) (public) (private)
- Shop, commercial
- Station (bus) (railway)
- Store
- Theater
- ***Excludes***
  - home garage (E849.0)
  - Industrial building or workplace (E849.3)

E849.7 RESIDENTIAL INSTITUTION
- Children's home
- Dormitory
- Hospital
- Jail
- Old people's home
- Orphanage
- Prison
- Reform school

E849.8 Other specified places
- Beach, Not Otherwise Specified
- Canal
- Caravan site, Not Otherwise Specified
- Derelict house
- Desert
- Dock
- Forest
- Harbor
- Hill
- Lake, Not Otherwise Specified
- Mountain
- Parking lot
- Parking place
- Pond or pool (natural)
- Prairie
- Public place, Not Otherwise Specified
- Railway line
- Reservoir
- River
- Sea
- Seashore, Not Otherwise Specified
- Stream
- Swamp
- Trailer court
- Woods

E849.9 UNSPECIFIED PLACE